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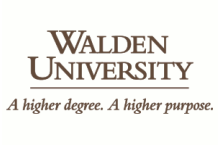

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Effects of Government Regulations and Reimbursement Policies on Home Health Administration in Illinois.

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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Sally A. Nwafor

has been found to be complete and satisfactory in all respects,
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Walden University
2020

Abstract

Effects of Government Regulations and Reimbursement Policies on Home Health Administration in Illinois.

by

Sally A. Nwafor

MSN, North Park University, 2006

BSN, Lewis University, 1999

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration – Health Policy

Walden University

August 2020

Abstract

Recent changes in government regulations and reimbursement policies threaten the financial viability and the ability of home health agencies to provide the necessary services. There is a gap in knowledge about the effect of the changes in healthcare policies on the administration of home health businesses in Illinois. The purpose of this study was to bridge the knowledge gap by investigating the effect of the regulatory and policy changes on home health administration in Illinois. The research question focused on the challenges that home health administrators face due to the changes in government regulation and reimbursement policies, and the strategies to cope with the changes. The institutional theory was used as the lens for understanding the topic of this study. A qualitative case study design was applied, which included document reviews and semistructured interviews of 12 purposeful sampled administrators from Medicare-certified home health agencies in the Chicagoland area in Illinois. The data from the interviews were recorded, manually coded, and categorized into themes for analysis through a content analysis approach. Results showed consensus expressions of regulations and policies- related financial and compliance burden on home health administration with some innovations for improvement in the quality of care. The results can prompt lawmakers to hasten the lifting of unnecessary regulations for efficient and sustainable home health services administration in ensuring a healthy population. Easing the burden of regulations on home health businesses by removing unnecessary compliance requirements will help the home health administrators to respond to the healthcare needs of Medicare recipients.

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Dedication

This thesis is dedicated first to my Lord Jesus Christ and Savior and my parents immemorial who was and still are my greatest fans, cheering me on all the way. I also dedicate this study to my children -Wisdom, Glory, and Josh, who has been a stable source of support, excitement, and encouragement during the challenges of my education and life. I am genuinely thankful for having all of you in my life. I dedicate this work to my husband, Gibson (Nkem), for your unconditional love. Also, to my siblings, their spouses, and children who have taught me patience, among other virtues, to work hard for the things that I aspire to achieve while remaining a role model to all of them.

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My sincere gratitude goes to the home health administrators who freely gave their time and resources in completing this work. Finally, I would like to thank my family- Pele, Victor, Queen (Mummy), Ugochukwu, Chioma, Kelechi, Ani, Ulunma, and Tobe, for their prayers, support, and encouragement. As numerous as my friends are, some cannot go unmentioned. So, I thank my dear friend Dr. Helen Okeke who prompted me to start this journey with her. I also thank Dr. Edmund Okoli - Prof for guidance, and Mrs. Ifeoma Okoli, Florence Jacobs, Anthony (Uncle T), and Tracy Nwaogu (Aunty Honey) for their support and gift of friendship. All of you have always been there for me through the challenges of postgraduate study, even when it seemed too difficult to overcome. Thank you all for the various ways that you have supported me, and at this time of graduation, you all will also rejoice with me in Jesus' Name, Amen.

Table of Contents

List of Tables

Chapter 1: Introduction to the study

Introduction

The implementation of new federal and state regulations and policies and changes to existing regulations that are intended to improve patient care and fiscal accountability has increased in the past 10 years (American Hospital Association 2017). Unfortunately, the magnitude of the impact of implementing these regulations and policies on the home health agencies in the State of Illinois is not fully understood (Polsky, David, Yang, Kinosian, & Werner, 2013). Among the legislations are the Health Information Technology for Economic and Clinical Health Act (HITECH), the Affordable Care Act (ACA), the Prospective Payment System (PPS), and the most recent Patient-Driven Group Model (PDFM). According to Hui-chuan Chen and Taylor (2016), the issues and challenges facing home health business operations are the uncertainties of ever-changing governmental policies and recent health care reforms in the United States. According to the National Association for Home Care and Hospice (2016), home health agencies have experienced several aggressive, progressive, and expanded government regulations and policies over the past two decades in response to market failure, system inefficiencies, and rising health care costs. While regulations may yield valuable public benefits and innovations, they are often imposed on organizations without full consideration or analysis of the benefits when compared to the loss of money and productivity that are incurred over time. According to Archbold, Hart, and Minarik (2019), these regulations are also associated with other issues of organizational constraints in-home health agencies' abilities to achieve economic and social goals.

Home health services are essential and inevitable options for many Americans, as shown by the high demand for home health care amid a rapidly growing aging population (Gutiérrez, Gutiérrez, & Vidal, 2013). Landers et al. (2016) projected that between the years 2000 and 2040, as more people turn 65 years, that this group of citizens will account for approximately 21% of the total population in the United States, thereby increasing the demands on Medicare program. According to Keehan et al. (2015), the United States spent 17.4% of the nation's GDP or approximately $9,255 per person annually on healthcare, and the GDP for health care in America is expected to reach up to 34% by the year 2040 if nothing is done to minimize the growing trend. Hence, the numerous healthcare reforms, such as the ACA that was signed into law in 2010 and the PDGM that was recently implemented in January 2020. These reforms and changes in the payment structures have considerable impacts on price, market structure, cost, and the quality of products or services that affected home healthcare funding and management (Case, 2015).

The role of home health in the care of the elderly, those with disabilities, and chronic disease remains relevant in the healthcare industry (Mukamel et al., 2014). However, government policies and regulations on the home health care sector has adversely, resulted in workforce limitations, distressed financing mechanism, and increased regulatory constraints on home health agencies (Landers et al., 2016). In affirmation of the assertions of Landers et al. (2016), Ortman, Velkoff, and Hogan (2014) reported that the rise in the demand for home health services comes with difficulty in meeting regulatory requirements of the Medicare conditions of participation and financial

challenges associated with meeting the rising demand for services, especially during a health crisis or pandemic. With the prevalence of chronic and disabling conditions, infection and mortality rates among the elderly population, there is an emphasis on the continued need for home care services for healthcare and support services (Mukamel et al., 2014). Therefore, meeting the need for the elderly to age with dignity, in line with their expectations, preferences, and care needs, will require understanding the issues and challenges that are associated with regulations and policy changes on home health agencies (Mukamel et a., 2014). This understanding will provide the home health agencies administrators with the information that they need to manage their businesses efficiently, strategically cope with the challenges, and adapt to the government policies and reimbursement changes in their operations (Boubacar & Foster, 2014; Milstead, 2013). The goal of this study is to understand how changes in government regulations and reimbursement policies in home health agencies have affected their administration. The outcome of this study provided insight into the perceived effect and the challenges that home health agency administrators encounter when addressing the requirements for compliance with government regulations and reimbursement policies

Chapter 1 of this dissertation contains the background and a description of some government regulations, policy changes, reimbursement systems, and their effects on the operations of home health organizations. This chapter also includes an overview of the problem statement, the purpose of the study, the research questions, and types of data that will be collected, analyzed, and discussed in the study. I also presented a preview of the theoretical framework, definitions of peculiar terms, the nature of the research, and the

methodology. Furthermore, I documented the related assumptions, the scope of the investigation, delimitation, limitations, and significance of investigating the problem.

Background

Home health services are designed to provide intermittent skilled nursing and therapy services, home health aide services, medical social services, and durable medical equipment to the elderly population with multiple acute and chronic conditions, impairments, and disabilities at home (Landers et al., 2016). The federal government regulates Home Health care through Medicare policies, occupational licensing, state insurance regulation, and the ACA (Archbold et al., 2019). The Medicare program is the largest and single-payer of healthcare services in the United States. The program is the primary source of income for many healthcare organizations such as home health agencies, and other providers of healthcare services for seniors that are over 65 years of age and for individuals with specific disabilities (Aoughsten, Johnson, Kuruvilla, & Bionat, 2014; Oberlander, 2015). Medicare policies and regulations are designed to control providers' entry into the healthcare market, remuneration, quality of care, competition, and safety in providing services (Landers et al., 2016; Wafula, Molyneux, Mackintosh, & Goodman, 2013).

Illinois was chosen for this study because it is home to 2,552,902 residents that are eligible to receive Medicare health coverage (Illinois State Department on Aging, 2017). Illinois has approximately 817 certified home health agencies provide services to this population (Data.Illinois.Gov., 2017).

Home health agencies in Illinois were identified as high risk for increased government expenses; therefore, was targeted by Medicare for the implementation of numerous legislative Acts (Archbold et al., 2019). For example, Medicare administrators invoked some items of legislation from the ACA policy to reduce reimbursement, conserve resources, and also encourage innovation on home health businesses in Illinois (Archbold et al., 2019). The ACA contains mandated provision of healthcare coverage for employees by the organizations and a reduction in reimbursement to home health agencies to control escalating healthcare costs (Rak & Coffin, 2013). One of the goals of the ACA reform was to make healthcare affordable and available to Americans by promoting quality of care and decreasing the cost with embedded provisions that restrict healthcare market entry. The reform included amendments to home health regulation, reforms to legislative and service delivery systems, and reimbursement, which are driven by the costs of care instead of other relevant factors. These factors include changing demographics in the population, a rise in the number of people with chronic conditions, disabilities, and functional impairments (Huckfeldt, Sood, Escarce, Grabowski, & Newhouse, 2014, Rak & Coffin, 2013). Consequently, home health businesses suffered direct economic pressures caused by several regulatory factors (Grant, 2017; Murphy & Free, 2016).

The federal government decreased Medicare reimbursement for home health services by reducing the number of approved visits that patients can receive in the home while imposing an increased level of scrutiny and auditing on home health agencies (Institute of Medicine; National Research Council, 2015). Changes to Medicare payment and reimbursement structure drastically reduced the advance payment to home health

agencies, made reimbursement more difficult, caused a reduction in the use of home health services and forced some agencies to exit the program (Paul III, Clemente, McGrady, Repass, & Coustasse, 2016). An estimated 20% of the nation's home health businesses closed down within the first year of home health payment restructuring by Medicare (Mukamel et al., 2014). Other government regulations that drastically affected home health operations in Illinois was the placement of a moratorium on home health agencies' entry into the Medicare program. The moratorium halted the opening of new home health businesses in Illinois. It was later extended to other metropolitan areas of Fort Lauderdale, Detroit, Houston, and Dallas, Texas (Center for Medicare & Medicaid Services (CMS), 2017; Herzlinger, 2006).

Despite the recorded adverse effects of the government regulation of home health care, these regulations and policy changes have supported innovations in the industry, such as the introduction of electronic medical records and telemedicine. Medicare regulations and policies have also created and sustained a more cost-conscious environment and positive business and leadership behavior in the home health sector (Kitching, Mark, & Wilson, 2013). However, the government's focus on the rising healthcare costs seemed to have overtaken the need to understand the challenges that the home health administrators face in their struggle to comply with government mandates and continue to provide services in a radically changing external environment (Huckfeldt et al., 2014).

Some authors examined the implications of government regulations and payment structures on home health agencies (Mukamel et al., 2014), and the effects of the Home Health IPS and PPS on payments, costs, and patient outcomes (Huckfeldt et al., 2014). Others explored how the changes in Medicare reimbursement have affected the growth and efficiency in the delivery of home health services (Landers et al., 2016; National Association for Home Care and Hospice, 2016). Other studies also focused on the decrease in utilization and the number of home health agencies due to policy implications (Medicare Payment Advisory Commission (Medpac), 2016). However, research on the issues and challenges in government regulations and reimbursement on the operations of home health agencies is limited. Furthermore, while some studies provided a global perspective of how these government regulations have affected health care services, this study focused on the challenges of the administration of home health businesses in Illinois. Therefore, there is a need for home health administrators to be knowledgeable about healthcare reforms and understand their effect on services and business administration to adapt to the changes that are continuously occurring in the industry (Milstead, 2013).

Problem Statement

Recent changes in government regulations and reimbursement policies threaten the financial viability and the ability of home health agencies to provide quality health in the State of Illinois (Marrelli, 2017). The implementation of these regulations and policies have also caused administrative burdens, financial loss, as well as positive innovations to home health care businesses (Marrelli, 2017). Home health proprietors

must understand the regulatory changes and adapt to them by developing business capabilities and strategies to cope with the effect of recent healthcare regulations on their business (Landers et al., 2016). The State of Illinois has 817 Medicare-certified home healthcare agencies that provide skilled services to the elderly and disabled population. These services are funded by Medicare to ensure that older Americans with severe chronic illness and others with disabilities can remain independent in their homes (Data. Illinois. Gov, 2017; Landers et al., 2016). Home health operators in Illinois have experienced the effects of government regulations and policies on home health services such as the imposition of a moratorium in 2013, the Pre-Claim Review program (PCR), and billing reforms in 2016 (Jennings, 2016). According to Huckfeldt et al., (2014), these changes considerably lowered the Medicare reimbursement thresholds for home health agencies, thereby changing the market environment and the financial incentives for home health agencies since the implementation. Research on the combined effects of these government regulations and reimbursement policies on the operations of home health agencies is limited and thereby needed.

Purpose of the study

The purpose of this qualitative case study was to understand the issues and challenges that home health Administrators face due to changes in government regulations and reimbursement on home health agencies. The target population included 12 home health administrators from Medicare-certified home health agencies located in the Chicagoland area in Illinois who have been in business for the past seven years. This preferred population was appropriate for this study because the administrators play

distinctive and intricate roles in the administration and provision of home health services. Also, according to Mukamel et al. (2014), home health agencies' entrance into and exit out of the healthcare market is dependent on the financial attractiveness, regulatory demands on the business, and changes in the payment structures. The implication for positive social change included the possibility of a better understanding of the effect of government regulations and reimbursement on the home health sector in addition to influencing future policy changes, the agencies' responses to these changes towards compliance, meeting the healthcare demands of growing elderly and disabled population, and ultimately, better health outcomes for the consumers (Santos, 2014).

Research Question

What issues and challenges have home health administrators in Illinois encountered from the changes in government regulation and reimbursement policies on the home health system?

Theoretical Framework

Addressing the question of home health administrator's perception of government's expectations through regulations and policies are relevant to this study because home health administrators are leaders who consciously or unconsciously behave in a specific manner to increase the legitimacy and survival of their businesses (Merali, 2014). In light of the evolving government regulations on home health agencies for participation, reimbursement, and quality standards, I employed the Institutional Theory (government regulation) as the lens for the study. Institutional Theory was used to build the framework towards understanding the effect of external influences such as

government actions on home health businesses and the agencies' strategic flexibility to adapt, align, and respond to external factors. The concept of institutional theory dated back to the era of Max Weber and Emile Durkheim but was first argued by Meyer and Rowan in 1977 and later by DiMaggio and Powell in 1983. These philosophers believed that organizations exist in a highly institutionalized context of various professions, policies, and programs, which serve as powerful myths (Hui-chuan Chen & Taylor, 2016). According to Lin and Sheu, (2012), originators of institutional theory posited that companies operate within a social network and exhibit different firm behaviors and that environmental pressures, economic and non-economic motivators could influence the leaders and shape the organization's behavior towards conformity to rules.

Nature of the Study

A Qualitative research method, using a systematic mode of inquiry, was used to understand the issues and challenges of government regulations and reimbursement policies on the administration of home health agencies (Maxwell, 2013). A case study approach was suitable for the study because the study was limited to the Chicagoland area and bounded in time. Qualitative research provides in-depth knowledge of the issue under investigation when conducted in the natural setting (Creswell, 2013). The application of a qualitative study approach to this study offered the opportunity for the use of an in-depth interview method to explore the human perception of the phenomenon under study. Such opinions are subjective and cannot be quantified by statistical means (Denzin & Lincoln, 2013*).*

The data for the study were obtained primarily through interviews with voluntary participants. The secondary data source included a review of documents, internet searches, and the researcher's field notes to understand and explain the problem. The use of multiple data sources in the exploration of this case study allowed for the examination of the subject through various lenses to reveal the many sides of the topic of research and enhanced its understanding (; Maxwell, 2013; Ravitch & Carl, 2016). The participants were selected through purposive sampling and are knowledgeable of the phenomenon under investigation.

The collected data were recorded in handwritten and electronic format for analysis. Data were hand-coded and categorized with the use of NVivo 11 software to manage and analyze the research data for efficiency and accuracy in the retrieval of the coded data for analysis. The resulting codes were pulled together to form themes that became headings for the interpretation of data and the presentation of the findings (Sutton & Auston, 2015). The use of NVivo enhanced data organization and management in the study.

Operational Definitions

This paper contains some technical terms that common language in addressing Medicare programs concepts, and they are defined below:

Regulation: This means to exact control or direct others through rules or standards which compels people to do things that they usually would not do (Drahos, 2017).

Medicaid: This is a federal government-funded health insurance program that is operated and regulated by individual states to provide health coverage for individuals with disabilities, seniors, pregnant women, and children (CMS, 2015).

Medicare: This is a type of health insurance program that is funded and managed by the federal government for US seniors that are over 65 years of age and for individuals with specific disabilities (Aoughsten et al., 2014).

Pre-Claim Review (PCR): A method for a rules-based preadjudication of a benefits claim whereby a claim for service is pre-adjudicated by Medicare rules before submission for payment to ensure compliance with the terms and conditions of the benefit plan and to minimize error in reimbursement (CMS, 2013).

Institution: A regulative, normative, and cultural-cognitive elements that provide stability and social meaning to life when combined with related activities and resources (Hoerndlein, Benlian, & Hess, 2012).

Assumptions

A researcher may find the process of conducting scholarly research to be challenging and humbling, especially amid limited resources and capability (Bouzon, Augusto, Miguel, & Rodriguez, 2014). The concept of assumptions, limitations, and delimitations are necessary components of a research study, which prevents readers from doubting the credibility of the research (Lo, 2016).

Assumptions refer to things that may be out of a researcher's control yet seem to make the study relevant and are accepted as accurate without the need for supporting evidence (Grant 2014). Also, Kirkwood and Price (2013) described assumptions as

statements that are recognized as authentic by the investigator and readers without verifying their validity. For example, I presumed that the participants would willingly and truthfully offer the information needed for the study, hence an underlying assumption of willingness and honesty.

Another assumption for this study was that the data obtained from using multiple data collection strategies would portray an accurate reflection of the participant's perceptions of the effect of and response to the changes in government regulations and reimbursement policies on home health agencies in Illinois. I assumed that the research participants understood that their participation and the level of involvement are without coercion, favor, or prejudice while providing information to me during the interview and group sessions (Issel, 2013). It was also safe to assume that the researcher ensured that all participants received the information related to voluntary withdrawal from participation at any time during the process without repercussions (Issel, 2013). Finally, I assumed that the outcome of this study would be applicable in making assumptions on the issues and challenges of government regulations and reimbursement policies on home health agencies across and outside Illinois, towards compliance and sustaining the home health business.

Scope and Delimitations

The scope of this study was restricted to home health agencies in Illinois, and delimitations included the participants' population, size, and research focus. The study focused on understanding the issues and challenges of government regulation and reimbursement policies on Medicare-certified home health agencies in Illinois. The

choice of a purposive sampling method produced a sample population of administrators from home health agencies that have been in business in the State of Illinois for over seven years. The selected population was chosen to provide rich and in-depth information towards answering the research question of identifying and understanding the issues and challenges that home health administrators encounter due to changes in government regulation and reimbursement policies and the agency's response to the changes. I included a presentation of a detailed methodology that will maximize the transferability and applicability of the findings and enable future researchers to apply the method in studying the phenomenon on other agencies in other regions.

Seven years of business operation was chosen as criteria for home health businesses because Medicare recertification occurs every three years as a condition of participation in determining agency eligibility for continued enrollment in the program. There was a possibility that the transferability and generalizability of the study outcome could be limited by the seven years criterion, especially for home health businesses in regions that were not affected by the moratorium.

Limitations

Limitations are possible loopholes or weaknesses in a study that is out of the researcher's control (Kirkwood & Price, 2013). This study on exploring the issues and challenges facing home health administrators in Illinois due to the changes in government regulation and reimbursement policies required a purposive sampling of administrators that have experienced and lived through the implementation of these initiatives over time. However, the self-reporting nature of the information provided by the participants may be

subject to participants' need to respond in a preconceived manner. Sometimes individuals may choose not to participate in studies if they perceive the need to compromise poses a risk that outweighs the potential benefits of collaboration. Therefore, a participant may feel uncomfortable in releasing detailed operational information in response to the questions. Data were obtained via interviews, which were audio and manually recorded in a journal and electronic formats for interpretation through the content analysis method.

Also, a sampling error may occur when there is a last-minute decline for participation from the participants for other reasons or death (Oppong, 2013). To minimize sampling errors, I considered the sample size carefully for adequacy and reached out to more people than I actually needed to recruit. The sampling method for the target population and the size of the participants may present a problem with the applicability and generalizability of the outcome to the home health agencies in Illinois. Secondly, the size of the organizations that the participants represent may also affect the application and transferability of the findings to other agencies with contrast sizes and agencies that operate under privately funded healthcare programs.

Another possible limitation to the research may be the possibility of a lack of structure in the interview process, which may pose a risk of generating unintended data that may cause a deviation from the proposed research goals and objectives (Spyros, 2014). Since the effectiveness of the qualitative research method and minimizing the limitations are dependent on the effort and competency of the researcher, I guarded

against personal bias, judgment, and interpretation of data that may interfere with the outcome (Bourke, 2014).

The Significance of the Study

The government regulations and reimbursement policies provide financial, advisory, and other services to the home health business community and simultaneously acts on protecting its interest. However, the government finds incentives to continually issue new regulations and policies without thorough evaluations of how productive or effective the existing rules are in meeting their objectives (Beales et al., 2017). Despite the good intention of these actions, the private sector is competitively affected by the implementation of government initiatives that tend to favor the public sector over home health care businesses (Iszaid, Hafizan, & Muhamad, 2018). This study is unique because it focused on an under-researched area of the double effect of regulations and reimbursement policies on privately owned, small Medicare-certified home health agencies. The result of this study might be instrumental in creating government awareness about the challenges that emanate from the changing legislation and policies that are aimed at increasing compliance and reducing health care costs. The relevance of this contribution will clarify the issues and problems that are associated with the enactment and implementation of government regulations on home health administration and offered future research opportunities. While the study lacked focus on the adaptive responses of the home health agencies towards Medicare mandates, examining the responses of home health agencies administrators to these changes was a vital component towards proposing an amendment to how regulations and policies are implemented and

enforced. These outcomes are relevant towards effecting positive change that will ensure adequate funding for home health business while requiring compliance with regulations, improvement in the quality of care, and implementation of effective strategies for the viability and sustainability of these organizations (Landers et al., 2016).

Implications for Social Change

A positive change from the role of the home health industry in public health services is possible through an understanding of the applicable government regulations and policies and the effect while responding to the regulatory requirements (Rollings, 2017). The government's reactions towards inefficient health care marketplace undue financial, operational, and administrative burdens on businesses (DiSantostefano, 2013; Wisk et al., 2014). These challenges are likely to compel home health administrators to approach regulatory compliance in innovative ways that could revolutionize the home health industry in a way that is beneficial enough to outweigh the effect of the perceived obstacles (Rollings, 2017). Also, reducing the financial and regulatory constraints on home healthcare businesses could empower home health agencies to increase service areas, the number of visits, provide safety, and efficiency of care, improve performance while complying with the regulations.

Summary

The continued growth in the demand for home health care attracts an increasing need to design a more efficient delivery system amid limited resources and regulatory constraints (Gutiérrez, Gutierrez, & Vidal, 2013). Government regulations of the home health industry and its reimbursement policies can influence the behavior and

performance of the organizations and the administrators' actions in response. An understanding of the effects of these changes is paramount in addressing the strategies needed to ensure compliance and adaptation (Santos, 2014). Despite the numerous regulations and health reforms over the past two decades, the challenge of resolving the disconnect between the expected quality, value-based care, and the regulatory effort with policy changes remains unresolved. Since the complexity of the home health care regulatory environment is far from being resolved, part of the responsibilities of home health agencies' administrators is the expectation of coming up with innovative means of adapting to the regulated home health care environment.

Chapter 2 included literature search strategies and keywords that are relevant to the search, a broad view of the theoretical framework, the history of Medicare home health care and government oversight, an overview of recent Medicare rules, and payment reforms. Also included are emerging innovation in the home health sector due to the implementation of the mandated initiatives, an overview of the effects of the policy changes on home health management, and the future of home health care. The chapter concluded with a summary of the impact of the policy changes on home health management and the need for effective strategies to cope with the changes while promoting compliance with rules and regulations.

Chapter 2: Literature Review

Introduction

The implementation of the government regulations and reimbursement policies have caused administrative burdens, financial loss, and innovations to home healthcare businesses, some of which threaten the effectiveness of the administration of home health agencies Illinois (Marrelli, 2017). The purpose of this qualitative case study is to understand the issues and challenges that home health administrators face due to changes in government regulations and reimbursement policies on home health agencies. While the federal and state laws have contributed to improvements in the quality of services and access to health care, these regulatory actions were also counterproductive to the operations of small home health agencies (Beales et al., 2017). American Hospital Association (2017), reported that providers across the nation spend approximately $39 billion annually in compliance due to increasing federal regulations. While the goals of the various regulatory programs receive public applause, in practice, control over the industry translated to detailed rules, more workload, and increased paperwork that can be very expensive and burdensome to the agencies that are mandated to comply (American Hospital Association 2017). Therefore, home health agency proprietors must understand the regulatory changes and their implications and adapt by developing business capabilities to cope with the effect that the recent healthcare regulations may have on their business (Landers et al., 2016).

This literature review provided substantiation and the foundation of the basis of inquiry for addressing the primary research questions regarding the issues and challenges

that administrators of Medicare-certified home health agencies face due to the changes in government regulation and reimbursement policies and how the administrators cope with these changes. The selected literature for review was taken from multiple databases and included scholarly journals, published articles, books, government data, and websites. This chapter consists of the following headlines: (a) literature search strategies, databases, and keywords that were relevant to the search; (b) a broad view of the theoretical framework; (c) the history of Medicare home health care and government oversight; (d) an overview of recent Medicare rules and payment reforms; (e) emerging innovation in the home health sector resulting from the implementation of the mandated initiatives; (f) overview of the effects of the policy changes on home health management, (g); the future of home health agencies. The chapter concluded with a summary of the effects of the policy changes on home health management and the need for effective strategies to cope with the changes while promoting compliance to rules and regulations. The content of this literature review demonstrated the significance and impact of government regulation and policies on small, Medicare-certified home health care businesses.

Literature Search Strategy

I completed multiple searches within the Walden Library database, primarily, ProQuest, Thoreau, SAGE, EBSCOhost. My search extended outside the library, to government websites, Science Direct, online newspapers/journals, and Google Scholar, textbooks from college libraries and government sources via internet search tools such as Google. I also reviewed peer-reviewed journals, books, expert reports, dissertations, and

multiple relevant Medicare websites. Keywords and phrases for searching for rich data for this study included: *Healthcare reform, home health reimbursement, Medicare home health agencies, pre-claim review, Medicare rules and regulations, healthcare policies, Affordable Care Act, Electronic health records, Prospective payment structure, Provider-Driven Group Model, Institutional theoretical framework, adaptive capability, and home health compliance.*

Peer-reviewed literature was the preferred reference material, but articles from other credible sources added value to the research. Most of the articles used in the review have publication dates that are within the five years of 2020. The analysis included some older articles that were carefully selected to enhance the understanding of the historical perspective of the subject matter. These older articles contain vital components of the issue and challenges that home health administrators face due to recent changes in government regulation and reimbursement policies while keeping the program viable to fulfill its objectives.

Theoretical Foundation

As the government reacts to the national growing health care cost and health care market failures, home health agency administrators find it more challenging to deliver quality health services with limited finances and constricting regulations (Burnett et al., 2015). The researcher in this study attempted to understand the pressures and challenges experienced by home health administrators to improve quality and reduce spending. Institutional theory dated back to the era of Max Weber and Emile Durkheim and was first argued by Meyer and Rowan in 1977 that changes in organizational behavior are

driven by external influences (Greve & Argote, 2015). Meyer and Rowan posited that organizations accept environmental impacts and comply with mandates from external mandates to gain legitimacy in the sector, which ensures its survival (De Jonge, 2015).

The institutional theory contains two theoretical frameworks, namely "environment as institutions" which focuses on organizations conformity to federal and state requirements and "organization-as-institution" with a focus on practices that are formulated within the institutions (Vadeboncoeur & Jennifer, 2018). According to Lin and Sheu, (2012), the originators of institutional theory posited that organizations operate within a social network and exhibit different firm behaviors in response to environmental pressures, economic and noneconomic motivators. These factors influence the leaders and shape the organization's behavior towards conformity to rules. Javanparast et al. (2018) stated that environmental pressures induce businesses towards what they identified as coercive isomorphism, normative isomorphism, and mimetic isomorphism. Coercive isomorphism is peculiar to the environment-as-institution framework that occurs when home health administrators act, as expected by the government, to avoid sanctions. Normative isomorphism occurred when organization leaders behave in ways that meet the norm or social expectations by adopting formalized routines. Lastly, mimetic isomorphism is peculiar to the organization-as-institution framework and occurs when the influencing institution succeeds in replicating compliance within other similar organizations (Javanparast et al., 2018). Since home health agencies do not operate in a vacuum, they must comply with governmental policies mandate to gain legitimacy and be rewarded with continued participation (Berthod, 2018).

I selected the institutional theory because of its universal applicability and acceptance across different sectors such as healthcare, climate change, economics, agriculture, and information science, as explained below. Institutional theory has been successfully used to explore how healthcare leaders attempted to balance external pressures and internal control to improve the quality of care and contain spending (Burnett et al., 2015). The institutional theory was also used to explore how pressures could be instrumental in stimulating organizational change (Hui-chuan Chen & Taylor, 2016). The environment-as-institution framework was applied in explaining the adoption of electronic health records (EHRs) in outpatient practices (Sherer, Meyerhoefer, & Peng, 2015); and also, to the study of information systems and the impact of individuals on non-organizational setting (Hoerndlein et al., 2012). Stranger, Wilding, Hartmann, Yates, and Cotton, (2013) applied the Institutional theory in a qualitative study on understanding how and why lateral transshipments - a government regulation - act as a coercive pressure towards ensuring the handling, storage, and transportation of blood supplies in the United Kingdom. Through the lens of the environment-as-institution framework, these authors explained why organizations adopt required policies and their reactions towards environmental pressures. The findings from Stranger et al. aligned with the results of other studies by Shi et al. (2012) and Azevedo, Remigio, and Cruz-Machado, (2010) on the case for green supply chain management – an organizational ideology- that uses regulatory compliance, environmental performance, and business efficiency, corporately, to reduce risks and impacts from regulations, to achieve profit

and market share objectives. Shi et al. argued that in responding to legislative mandates with compliance, organizations could gain competitive advantage and long-term benefits.

The CMS, as a government institution, have regulative, normative, and cultural-cognitive elements that provide stability and social relevance to home health agencies when combined with resources and authority (Berthod, 2018; Javanparast et al., 2018). These regulative aspects may be coercive and force home health agencies to adapt and act in prescribed ways amid pressures. (Hui-chuan Chen &Taylor, 2016; Javanparast et al., 2018).

Review of the Relevant Literature

History of Medicare Home Health Care and Government Oversight

The enactment of the Medicare program in 1965 expanded and accelerated the home health services that started over a century ago to the elderly and then to specific disabilities in 1973. However, the growth of home health agencies in the United States plateaued in the mid-1980s due to regulatory burden and unstable payment patterns from Medicare (National Association for Home Care & Hospice (NAHC), 2010). Medicare home health care includes skilled nursing, physical therapy, occupational therapy, speech therapy, aide service, and medical social work services that are provided to patients in their homes (CMS, 2017). Eligibility for these services includes the inability to leave home without considerable effort termed “homebound,” need for intermittent skilled services, physician certification, and oversight of the services that are provided in the patients’ home (CMS, 2017; MedpAC, 2011). Through the Medicare program, the government provided health and welfare services to older and disabled citizens with the

assurance of access to health and protection from financial hardship that could result from medical bills (Blumenthal, Davis & Guterman, 2015). Medicare based the payment for the home health care services on patient severity - clinical and functional conditions - in a 60-day episode, which recently changed to a 30-day episode per the terms of the Patient-Driven Groupings Model (PDGM) (CMS, 2019). Davitt & Choi (2008) examined the impact of government policies on home health agencies and benefits. These authors concluded that policy enactment and implementation on home health delivery system requires a collaborative effort of all three branches of government. According to these authors, the actions of the government branches regarding Medicare administration has been somewhat antagonistic to one another. For example, the legislative branch of the government enacted and passed the initial changes to the Medicare program to make home health services more accessible to the beneficiaries. This legal action was followed by a restriction of the program eligibility by the executive branch through the CMS. CMS restricted program eligibility by increasing oversight and creating new program rules which were subsequently overturned by the judicial branch by changing the oversight process while expanding Medicare eligibility (Davitt & Choi, 2008).

In the history of Medicare home health programs, government interventions through policies and regulations have been shrouded by cost rather than a response to the legitimate need to improve the quality and delivery of home health care (Davitt & Choi, 2008; Whittington et al., 2015). However, these interventions may be justified by an increase in Medicare spending on home health between 1998 and 1996 up to 31 percent

annually (McCall et al., 2001). The recorded increase in spending prompted the United States Congress to justify the case for cutting down spending in home health services in 1997. The United States Congress declared that the rise in home health spending is higher in comparison to other Medicare programs. Subsequently, the US Congress passed the Balanced Budget Act (BBA) of 1997, which overhauled the Medicare program, especially the home health services (Davitt & Choi, 2008; McCall et al., 2001). These authors stated that under the BBA, Medicare changed the reimbursement structure to an "Interim payment system" (IPS), which was a precursor to a more permanent prospective payment system (PPS). The goal of IPS was to decrease spending rapidly. The implementation of IPS reduced home health payment down to the rates of 1993 and limited payments per user. The limited payment caused a dramatic change in home health administration, including forcing home health agencies to participate in risk-sharing responsibility and the exit of over 3,800 agencies from the Medicare program nationwide (Davitt & Choi, 2008, Gabrowki et al., 2012).

With the rapidly changing demographic trends of the increasing aging populations, Medicare initiated a "Triple Aim" movement in 2009, which was a strategy to improve patient experience, population health, and reducing cost per capita of healthcare (Landers et al., 2016). The triple aim framework was the foundation for the implementation of numerous innovations for population and services management, including the ACA mandates of 2010, which tied Medicare traditional payments to providers to quality and value of their services (Landers et al., 2016; Whittington et al., 2015). According to Ackerly and Grabowski (2014), ACA reforms offered a more

efficient payment structure for some Medicare products with the bundled-payment system, which created a capped episodic payment amount for home health agencies. However, these authors argued that ACA reform placed burdensome payment regulations and rules on home health administration. These authors further stated that some items in the ACA, such as the fixed payment for a 60-day episode of home health care, limit the flexibility practitioners have in ensuring planning and delivering individualized care according to needs and could hinder quality service delivery.

An Overview of Recent Medicare Rules and Payment Reforms

The rise in Medicare program spending accounted for a large portion of the federal budget for the past two decades as more people qualified for Medicare benefits (Burke & Kamarck, 2016). Therefore, the CMS administrators added more regulations and policies which are designed to strengthen and increase oversight of Medicare home health providers (CMS, 2014). A significant change in government reimbursement policy is the introduction of a prospective payment system (PPS). PPS is a multiple-level classification scheme that allows vendors to receive a predetermined amount that is based on a coding system for the types of services they provide (Suresh et al., 2014). In qualitative research on the future of home health care, Landers et al., (2016) identified the challenges that have evolved with the changes in regulations that targeted home health service provision and delivery process. These challenges included financial and regulatory constraints from the changes in Medicare payment structure such as the PPS, which links payment to health services to providers' performance (Landers et al.). PPS was implemented by Medicare to curb rising healthcare expenses by detecting fraud or

abuse using a coded payment system, yet, Medicare home health costs continue to proliferate since its implementation (Cabin et al., 2014; Suresh et al., 2014).

In addition to the financial implications of PPS on home health agencies' administration, CMS adjusted the standardized 60-day episode rate to reflect changes in the number of visits, case mix, the intensity of services and the cost of providing service per episode under the direction of ACA, (CMS, 2017). The adjusted payment was applied in equal increments over four years up to 3.5 percent, which represents a 2.3 percent decrease in home health PPS payments in 2017 (CMS, 2017). According to Rosati et al., (2014), advocates for home health care providers opposed the rebasing implementation, arguing that that the reduction will decrease access to some patients and that providers need some leverage in profit to invest in service infrastructure and response to the changing regulatory requirements on the organizations.

Another government regulation that has changed the trajectory of home health care administration is the mandated integration of technology, such as electronic health records (EHR) and telehealth in the home health delivery system. Landers et al., (2016) argued that monitoring the patients' health status without an actual face to face visit will involve innovations such as health information technology (HIT) capabilities, telehealth, and adequate, trained staffing to coordinate care, communication, and transition support. This mandated integration of technology does not necessarily attract full Medicare reimbursement (Kruse et al., 2014). Kruse et al. stated that CMS acknowledged the use of health information exchange and HIT tools are essential for improving the quality of care and lower service costs. However, all post-acute care providers, such as home

health agencies, are not eligible for Medicare incentive that is available for acquiring these tools and other technological capabilities. Home health agencies bear the cost of compliance with CMS rules and mandates without incentive or reimbursement from the government. The unreimbursed expenses contribute to the challenges that could threaten the financial viability of the organizations (Jarrin et al., 2014). In support of Jarin et al. and Aiken's assertion, Boling (2010) explored the role of human factors in sustaining the survival of home health care. Boling stated that the primary obstacles for home health settings are related to the lack of consistency in national policies that guide the care they provide and posited that Medicare condition of participation for home health agencies does not align with the reimbursement system.

The Patient Protection and Affordable Care Act (ACA) was enacted to ensure access to quality, affordable health care and a transformation of the health care system necessary towards cost containment costs (Wanamaker & Bean, 2013). The ACA authorized Medicare to impose a temporary moratorium on the enrollment of new Medicare, providers, and suppliers in high-risk regions, when necessary, to prevent or combat fraud, waste, or abuse of public funds (Mitka, 2013). Based on this authority, Medicare implemented its first-ever moratorium in 2013 and halted the establishment of new home health agencies in the metropolitan Chicago area covering six counties (Medicare, Medicaid & children's health insurance programs, 2014). The moratorium was later extended to the entire States of Illinois, Florida, Michigan, Texas, for seven years. While the National Association for Home Care and Hospice (NAHC) supported

the implementation of the moratorium on areas that were identified to be high risk for fraud, the organization disagreed with its application on a state-wide level (CMS, 2017).

The ACA also compelled home health agencies with up to 50 full-time employees to provide them with health insurance, which prompted small agencies to alter their employees' size to remain in business (Herrick, 2014). Dillender, Heinrich & Houseman (2016) explored the effects of the shared responsibility provision of ACA on short-hours and part-time employment, which are typical for home health agencies. The authors concluded that the rule affected the resources, financial profitability, and business operations of home health agencies. As part of the ACA provisions, MedPAC (2015) reported that Medicare had initiated a four-year reduction in the base-payment on home health agencies to evaluate the effect of cuts in reimbursement on the quality of care and access to home health services. The four-year phase of a new payment system reduced home health agencies compensation by 0.4% or $80 million in 2018 and up to $950 million in 2019 and will also replace the current 60-day episode of care unit with 30 days (CMS Health and Human Services (HHS), 2017). The ACA also authorized the initiation of accountable care organizations by transforming traditional fee-for-service reimbursement models into pay for performance approach that rewards preventive measures and cost containment (Doarn et al., 2014). These actions served as incentives for home health agencies to explore alternative innovations towards engaging and meeting the needs of home health care recipients while maximizing the potentials of the limited resources provided by Medicare. CMS also published a proposed new payment structure in July 2017 that became effective since 2018. The new proposal was supposed

to encourage or incentivize home health agencies to explore innovations and collaborations that will extend beyond the industry's quality standards (Healthcare Finance, 2016).

In 2016, CMS initiated a three-year Pre-Claim Review (PCR) process to prevent waste, reduce home health spending, sustain, and improve the quality of care, starting with Illinois (NAHC, 2016). The PCR was revised and re-implemented in June 2019 as a Review Choice Demonstration (RCD) in Illinois, Ohio, North Carolina, Florida, and Texas (CMS, 2019). According to CMS (2019), the purpose of the RCD is to protect the Medicare trust fund by testing whether the RCD improves strategies to investigate and prosecute fraud in home health services. Under this program, Medicare required home health agencies to submit supporting documentation for medical necessity, a term that has been poorly defined by the CMS, for the determination of reimbursement (Jennings, 2016). An organization that opts for a minimal documentation review will be subjected to a 25 percent reduction in payment (CMS, 2019). Jennings, in a study of the PCR, stated the NAHC reported an increased rejection rate of 22 percent in unreimbursed care due to denial of submitted claims and documentation of medical necessity from home health agencies. According to the Vice President of Law at the NAHC, Medicare central office, the Medicare Administrative Contractor (MAC) neglected to ensure the proper process for the implementation of the program, which resulted in the loss of submitted documents on a large scale (2016). The NAHC report stated that the outcome of PCR implementation in the short-term resulted in decreased access to care and the financial handicap of some home health agencies. NAHC also reported that agencies' responses to

the PCR correlated with a decrease in the number of home health visits and an increase in the rehospitalization rate of home care patients due to deterioration in health status resulting from a lack of needed home health care (NAHC, 2016).

Emerging innovation in the home health sector due to government regulations

Amid the issues and challenges that home health administrators encountered due to increasing rules, policies, and penalties, home health agencies are also required to comply with the use of electronic health records (EHRs) directive (Kruse et al., 2016). Despite the recorded and apparent benefits of the use of technology in healthcare such as efficient communication, information sharing method among providers, reducing health care spending, improved care coordination and management, the Health Information Technology for Economic and Clinical Health (HITECH) Act excluded home health agencies in its provision of incentives in the adoption electronic health records (EHR) (Kruse et al., 2014). In a pre/post, mixed-method, observational study on a home care agency with 137 clinicians, Sockolow et al., (2014) reported that the use of EHR resulted in a sustained increase in productivity and timeliness of documentation and billing for reimbursement with limited effect on improvement in patients' outcomes. EHR also replaced the office-based data entry version and freed office staff for redeployment to other areas of operations within an agency. Taking advantage of the benefits of EHR could be challenging due to financial and technological resources constraints related to the implementation, lack of expert technical and field support for clinicians, inadequate training and inefficiency resulting from disjointed EHR usability and functionality in the

workflow, user perceptions of the system and other technical implementation barriers. (Kruse et al., 2014; Sockolow et al., 2014)

In addition to the EHR, home telehealth monitoring was introduced into the home health sector as an alternative for sustaining operations with limited financial resources by reducing the number of home health care visits (Doarn et al., 2014). The use of telecommunication technologies to connect health practitioners to the point of care has been around since the 19th century and ranged from the use of the telephone to decrease unnecessary physician visits to the use of remote NASA monitoring system to check on the physiological functions of astronauts in the space in the 1950s (Doarn et al., 2014; Dinesen et al., 2016). The home telehealth monitoring is a remote system that involves the use of interactive audio and video transmission technology to monitor a patient's condition at home (Radhakrishnan et al., 2016). In a qualitative study by Radhakrishnan et al., these authors concluded that the adoption of telemonitoring home system was not cost-effective and did not impact patient referrals to the agency.

The remote patient monitoring (RPM) devices have in-built physiological parameters such as weight, blood pressure, oxygen saturation respiratory rate, and heart rate in the patient's home with real-time transmission to a virtual office (Husebo & Storm, 2014). Husebo & Storm (2014) conducted a literature review of articles from three significant databases concluded that remote monitoring through virtual visits compliments does not replace face to face clinician home visits. The authors also stated that patients were satisfied with virtual visits, which were deemed suitable for care delivery to the elderly at home but found no evidence for the cost-saving benefits of

virtual visits. Dinesen et al. (2016), affirmed that the use of RPM could decrease the rate of emergency room use and admissions, improve compliance with the treatment regimen and increase patient satisfaction and overall quality of life. Therefore, they disagree with the assertion made by Husebo & Storm that there was no cost-saving benefit to RMP. Dinesen et al., also agreed that while the devices used in RPM allow for interactive communication between clinicians and patients, it also has its patient-specific challenges. These challenges may include ensuring that the tool is user-friendly, the need for cognitive and physical effort on the patient's part for the equipment operation. Hence the conclusion that the use of RPM is not suitable for clients with cognitive or physical impairment. Researchers also suggest that home health agencies that decide to adopt an RPM system will probably face the challenge of clinicians and patients' acceptance of the devices (Dinesen et al. 2016). Other concerns regarding the use of RPM included the lack of government reimbursement, database compatibility, and technical capacity needed to integrate the system into the agencies (Dinesen et al., 2016; Husebo & Storm, 2014).

In support of the findings on the benefits of RPMs, Madigan et al. (2013) added that the use of RPM was cost-driven and regarded as a "nurse extender" towards reducing the number of home visits by clinicians per patient. Other authors also advocated for a collaborative approach for large-scale implementation of telehealth in the home health businesses towards the sustenance and support for Home health services (Wade et al., 2016). A significant factor in the success of the proposed level of implementation lies on leadership support that is evidenced by the acknowledgment of telehealth as a solution to

some of the barriers from service demand, funding the project and getting clinicians buy-ins by demonstrating the alignment between telehealth and health service policies (Wade et al., 2016). Despite some anticipated challenges with the implementation of RMP in the home health system, these authors affirmed that telemonitoring is effective in reducing the rate of acute care hospitalization because it allows for early recognition of deterioration in a patient's condition that will prompt early intervention. Furthermore, Medicare funds cover some telemonitoring equipment for patients with a qualifying diagnosis such as congestive heart failure coupled with renal failure or diabetes and other morbidities (Wade et al., 2016). Wade et al. also stated that some RPMs are user-friendly, portable, wireless, require training for the patients and caregiver on the use of the devices and remote support that virtually monitors the patient's condition.

Overview of the effects of the policy changes on home health management.

The home health sector is highly regulated by each state and federal government through CMS, with a constant revision to the Conditions of Participation that increases the organizations' responsibility in managing and improving the quality of care and costs and the federal government. (Cole, 2018; Grant, 2017). The effects of government regulations and policies can be classified as economic, regulatory, and administrative. The government rules for private sectors purportedly serve some public interest while imposing the costs of such regulations on private organizations. Since external costs add to organizations' inefficiency, organizations perceive regulators as an adversary (Elias, 2017). Enforced compliance with regulations is regarded to have economic effects and contrary to the interests of an organization (Elias, 2017). In support of the assertions

made by Elias, Beales et al. stated that regulatory mandates come with costs that are not controlled by the spending programs and are born outside the government, by the organization s who are compelled to comply with the rules (2017). However, contrary to the beliefs of Beales et al., Elias argued that corporations need to perceive regulatory compliance as legitimate and beneficial to corporate interest instead of a source of external costs that need to be avoided. Elias concluded that organizations should make compliance to regulations a corporate goal rather than a constraint.

A typical Medicare-certified home health agency is small and poorly funded, which increases the agencies' inability to fully comply with the continuum of government regulations for participation and fraud preventions (Landers et al., 2016). Landers believed that partnership between home health agencies and Medicare Advantage plans and providers who take on financial risk and ensure coverage of a large geographic area and round the clock services is the key to remaining viable and operational in the environment created by the Medicare. For example, the Medicare program requires home health agencies to, (a) provide individualized patient and person-centered care and operate in a seamless and well-coordinated connection with primary care providers, professionals, other services, supports, and suppliers; (b) ensure a consistently high quality of care while changing the care delivery methods; and (c) increase patient monitoring to improve health outcome through the use of technology without incentive payment or related reimbursement (Landers et al. 2016). Despite the expensive, mandated rules and proposed payment system, Landers stated that many home health

agencies are implementing the non-reimbursable strategies for improved care coordination, efficiency, and better patient outcomes out of pocket.

The amended Social Security Act Section 4615 of the Balanced Budget Act of 1997 established the eligibility and requirements for participation in Medicare home health benefits for its beneficiaries. Eligibility for Medicare benefits is reserved for those who (a) are homebound, (b) with verifiable medical necessity, and (c) are under a physician's plan of care (Landers et al., 2016). As simple as this definition may seem, the interpretation and application of the conditions of participation still need clarity for compliance by home health agencies operators and physicians who provide home health services to beneficiaries (Donelson et al., 2001; Landers et al., 2016). Consequently, home health agency operators have reported frustrations over the inconsistency and wide variation of interpretation of Medicare rules such as lack of standardized application of homebound and medical necessity criteria for home health services (Landers et al., 2016). To clear some of the confusion related to the interpretation of the requirements set by Medicare for home health services, some advocates of home care for the elderly proposed removing the "homebound requirement" from the criteria and instead, to focus on physical limitations and chronic conditions of the (Landers et al., 2016).

In 1999, CMS introduced an assessment tool for home health agencies - Outcome and Assessment Information Set (OASIS) - a patient-specific, standardized assessment for agencies' use in planning the care of the patient, reimbursement and measure the quality of care (Mukamel et al., 2014). These authors posited that the data from OASIS are used by CMS to determine the Home Health Resource Group's (HHRGs) case-mix

index, for reimbursement and has gone through continuous multiple revisions since inception. They also claimed that the OASIS tool reflects a severe misalignment between Medicare policies and quality improvement in services rendered through home health care. For example, the homebound Medicare eligibility restricts the agencies' ability to continue care for the depressed patient just because they can leave home without much effort or assistance by another person or assistive mobility devices. Bao, Eggman, Richardson, & Bruce (2014) added that the inclusion of a two-item screening tool in the OASIS during the start of care only without provision for follow up is a barrier to the nurses in providing adequate assessment and management of patients condition for the duration of care. According to Mukamel et al., the OASIS dataset has high inter-rater reliability for measuring the clinical and functional characteristics and an acceptable validity for measuring the cognitive status of admitted home health patients. On the contrary, other authors believe that the reliability and validity of the Medicare mandated OASIS tool is inconclusive, and that the results vary depending on the examined items and that the tool which has changed over time is still evolving (Bao et al., 2014; O'Connor & Davitt, 2012;).

In 2014, CMS required home health agencies to obtain physician face to face encounter certification to determine home health service eligibility for patients without providing adequate guidelines on its interpretation of a complete physician narrative on the certification. Compliance with the face to face requirement is tied to reimbursement without training or incentive to the physicians to support compliance (Bajcsi & Schlanger, 2014). According to a study from the Office of Inspector General (OIG),

home health agencies' compliance with the face to face documentation requirement was at 32 percent (Bajcsi & Schlanger, 2014). The OIG conceded that the home health organizations could not compel the physicians to complete and endorse the certifying documents and recommended that CMS makes the process seamless by standardizing a face to face encounter form and train physicians' groups on compliance (Bajcsi & Schlanger, 2014). Medicare regulations for health care are continually changing the home health delivery environment and places financial and regulatory constraints, challenges in maintaining program integrity and guarding against fraud and abuse, workforce limitations, and the burden of measuring performance in a competitive environment (Boling, 2010).

The future of home health organization

A report from the Forum on Aging, Disability, and Independence (2015) indicated that innovations aimed at the integrations of health systems that will affect home health care would emerge as a result of changes in home health policies. The workshop participants reported that although home health care is a small component of the suggested health systems reforms, they are unsure about how well the sector will conform to the new models. Landers et al., (2016) examined the future of home health care considering the recent transformations in the healthcare industry with an emphasis on the financing mechanism, regulatory constraints, program integrity, and the requirement for a technological interface. The authors interviewed vital stakeholders from CMS, policymakers, providers, and patients. They concluded that home health organizations stand to gain from an upstream referral from increased utilization, payment, and service

delivery reforms in the future if they meet the required standards of the present. The article showed how government quality and value programs, such as the bundled payment directed at the acute care settings affect the home health programs. Landers et al. elaborated on the prospective payment system for home health services, which does not cover reimbursement for required capabilities that are essential for coordinated patient care such as electrical medical records and telehealth.

Wade et al. (2016) directed their research on the transition of home telehealth into a wide range and sustainable service for the delivery of specialized services that healthcare facilities such as the hospitals usually provide. The authors interviewed 19 senior clinicians, managers, and service staff for the study and affirmed the capital-intensive nature of the non-funded project would hinder successful implementation. Wade et al. reported that despite the proven positive outcomes of telehealth in care coordination, integration, and transition, there is still resistance towards a full embrace of the project. These outcomes included reduced staff travel time and timely intervention. The authors found that financial involvement, patients, and clinicians' acceptability of the product and leadership support are the critical determinants for the implementation of the telehealth technology in home health organizations. Landers et al. (2016) reported that CMS expects that the home health agency of the future has the technological and structural capabilities to integrate other services and providers beyond the care they provide. Similarly, Wade et al. asserted that healthcare service payers require home health organizations to ensure that their services accessible, affordable, patient-centered, timely, integrated, and cost-effective.

The role of the home health agencies is changing and expanding as more expectations are placed on them to provide needed services to the increasing number of the aging American population with increased life expectancy and living with acute and chronic conditions (Landers et al., 2016). Landers et al., and Wade et al. called on policymakers to consider reducing regulatory constraints and create incentives to support logical coordinated care among providers. These authors also called on regulators to address the challenges that home health agencies encounter in the process of fulfilling their mandate under Medicare's objectives. These objectives include (a) improving patient experience of home health care; (b) improving the overall health of the aging populations, and (c) reducing the cost of healthcare (Alaiad & Zhou, 2014; Romagnoli et al., 2013). The authors also believe that the home health agencies will have more opportunities for adapting to the new changing reimbursement, care coordination, and risk-sharing healthcare environment.

Summary and Conclusion

This literature review highlighted the various aspects of home healthcare regulations, funding, innovations, and responses to government interventions, as recorded in the existing literature. The chapter contained an examination and presentation of some available research on the need for further clarification of the Medicare program rules to enhance compliance and the future of the home health industry. The demand for home health care services in residential settings instead of acute care or long-term centers is rapidly increasing with the rise of acute and chronic health problems (Suk, Hyun, Storfjell, & Kim, 2013). The Home Health program is designed to decrease costs,

improve health outcomes, and reduces hospital readmission and stays (Alaiad & Zhou, 2014). CMS estimated the number of home health agencies to be approximately 12,600 across the United States, which serves more than 2.4 million beneficiaries annually (Suk et al., 2013). Suk et al. also noted that the increasing demand for home health services contributed to the escalating healthcare cost, hence the government response to rising costs with the implementation of government initiatives (Suk et al., 2013). These initiatives came at a price for the government and the home health agency and resulted in innovative strategies that created additional workloads for the agencies (Jennings, 2016). CMS placed more regulatory and financial burdens on home health agencies and, as such, must partner with risk-bearing entities and go beyond their expected role in managing patient care to meet CMS expectations and condition of participation in the Medicare program (Landers et al., 2016).

The highlights of chapter 2 included a literature search strategy, databases, and keywords, a broad view, and the application of the institutional theory with its relevance to the study, an overview of Medicare rules and payment reforms, and the outcomes of the implementation of government initiatives. The chapter also contained an overview of the effects of the policy changes on home health management and the future of home health agencies.

Chapter 3 provides a full description of the method/design for the study and the rationale for the choice, the role of the researcher, the study setting, participants sampling method, the target population, data collection methods and instruments for the study. This chapter also contains the ethical consideration relating to the protection of human

subjects, anticipated benefits, and any identified potential risks and the platform for the transition into the section where the data results from the interviews, study conclusions, implications for social change, and recommendations.

Chapter 3: Research Method

Introduction

A study design provides the framework for collecting and analyzing data to ensure that the information obtained from the data collection process offers the desired answers to the research question (Creswell, 2013). The purpose of this qualitative case study is to understand the issues and challenges that home health administrators face due to changes in government regulations and reimbursement on home health agencies.

In this chapter, I provided a full description of the method/design of the study and the rationale for the choice of approach, the role of the researcher in the study, participants selection and sampling method, setting, target population, data collection methods, and instruments. I also described the protection of human subjects, anticipated benefits, and potential risks for participation, in addition to data analysis and the strategies for assuring credibility, transferability, dependability, trustworthiness. The chapter concluded with a summary and sets the platform for the transition into the next chapter for the presentation of the data from the interviews, study conclusions, implications for social change, and recommendations.

Research Design and Rationale

Qualitative research was best suited for the study of small samples that are intended to yield results that are not measurable or quantifiable (Creswell, 2013). The qualitative method of research was preferred and better suited for the study of the issues and challenges that home health administrators face due to the changes in government regulation and reimbursement policies on the home health system in Illinois. By utilizing

a qualitative case study design, I described my understanding of the experiences of home health administrators from the implementations and enforcement of Medicare regulations and reimbursement policies in the home health sector. Examining the experiences and the plights of home health administrators and how they have coped with the evolving business environment while providing health care services in the Chicagoland area was completed by the use of a single case study design. This design allowed for a more focused, narrowed, and an in-depth study that facilitated an analytic generalization which may be useful in studying another aspect of the phenomenon (Yin, 2014). The study was completed by utilizing data from a variety of data sources that allowed for multiple aspects of the event to be revealed and understood. (Rudestam & Newton, 2015).

A qualitative case study approach provided a method for examining contemporary events with the use of multiple data sources such as document reviews and interviews (Yin, 2014). Case studies are known to facilitate an in-depth exploration of the subject matter, using various methods of data sources (Angelelli & Baer, 2016). This case study explored the perceptions, actions, attitudes, and statements made by the participants during the interview sessions, document review, and analysis of various government websites. The information obtained from interviewing purposefully selected participants provided rich data from their experience and first-hand knowledge about the subject matter on a one-on-one basis (Palinkas et al., 2015). By applying a case study approach, the information needed to answer the research question was detailed and vibrant while presenting an opportunity for clarification. Also, a case study approach facilitated the description and analysis of the research topic without constricting the scope of the study

or limiting the nature of responses from the participants *(*Hyett, Kenny, & Dickson-Swift, 2014). The approach provided the researcher with opportunities to mine a detailed description of participants' perception of an event or a process within a real-world setting. Also, the case study approach offered the flexibility of accommodating the incorporation of present and new components as the study proceeded through the inductive reasoning (Bernard, 2013). Spyros (2014) added that the case study method creates a platform for participants to share information on their understanding and perception of events and processes.

While quantitative and mixed-method approaches are possible options for this study, the nature of understanding the issues and challenges related to the changing regulations and policies on home health businesses does not involve the use of statistical analysis or hypothesis testing. Therefore, they were not appropriate for the research (Creswell, 2013). Furthermore, the case study approach has gained popularity and acceptability, and many prominent authors are contributing to the development of the methodology (Creswell, 2013; Hyett et al., 2104). In comparison to the grounded theory or phenomenology approach, the case study approach offered more flexibility to a researcher (Hyett et al. 2104). According to Creswell (2013), a qualitative research method provides an in-depth understanding of the topic under investigation when conducted in the natural setting. The approach also provides opportunities for participants who have lived through the phenomena to describe their experiences and find common grounds (Creswell, 2013). Yin (2013) described the case study approach as a

comprehensive research strategy that relies on previously developed theoretical propositions for navigating data collection and analysis.

Finally, a qualitative case study research design provided numerous strategies that enhanced data credibility through the triangulation of data sources and data types from multiple perspectives (Hyett, Kenny & Dickson-Swift, 2104). Triangulation is the use of a combination of methods or data sources in qualitative research to enhance the understanding of a phenomenon and increases the confidence of the researcher and the readers in the findings of the study (Heale & Forbes, 2013). Also, Creswell (2013) affirmed that the collection, analysis, and interpretation of data enhance data quality based on the convergence and the confirmation of the findings. Sources of data collection for this study ranged from document review, interviews, to field notes, which enhanced access to a variety of information and triangulation that was useful for comparing the findings across the different methods. For instance, I explored the financial implications from changes in government reimbursement policy, the emerging innovations and the concern over the future of the home health business that was revealed in the recent literature review through discussions with the participants during the interview sessions for further verification (Johnson et al., 2017). The outcome of the conversations was useful in reducing bias and promoting validity, reliability of the information that I applied towards producing the final findings of the study (Heale & Forbes, 2013; Johnson et al., 2017). I also used triangulation to check for consistency in the results that I obtained from the different data collection methods. Therefore, a qualitative case study approach was a befitting method for this study that explored a real-

life system over a period through data collection with the use of multiple sources of information. The method was preferred over quantitative and mixed methods (Creswell, 2013).

Role of the Researcher

My primary role in this qualitative case study was that of the instrument, which involved data collection, evaluation, and interpretation (Abildgaard, Saksvic & Nielsen, 2016). In defining the research concept, Sanjari et al. (2014) stated that the researcher's role includes authentication, transcription, and analysis of data. Sanjari et al. posited that the extraction of reliable information for trustworthy outcomes in qualitative studies comes with some ethical challenges to the researcher. Achieving the desired result in research requires that the researcher defines the target population, screening, selecting, arranging meetings and interviewing, collecting, sorting, and coding the information from the participants in the study (Sanjari et al., 2014; Whiteley, 2012). Fulfilling the above role successfully in emergent research situations required an application of the necessary skills, such as the interviewing skills, maintenance of a sustained relationship with participants, and direct supervision of the process (Sanjari et al., 2014).

My role as the primary research instrument demanded some consideration of the participants' natural setting when selecting the meeting venues, dressing, timing as means of enhancing communication, gaining trust, and forging relationships (Sanjari et al., 2014). A researcher is emic – an insider - to the study and required full participation (Issel, 2013). Therefore, the researcher fulfilled the moral obligation of protecting the rights and welfare of the study participants by obtaining consent, maintaining

confidentiality, and addressing all relevant ethical concerns related to qualitative studies (Yin, 2014; Issel, 2013). Voluntary participation and privacy required the sensitivity of the researcher and attentiveness to the participants' concerns and views (Issel, 2013). The researcher assured the protection and confidentiality of the participants, which encouraged the participants to volunteer relevant information, enhanced the validity of the data that are released, and conveyed respect for the participants and the integrity of the researcher (Dooly, Moore, & Vallejo, 2017).

The attribute of a competent researcher is not innate but results from learning experiences and mitigating any personal bias that may interfere with how data is interpreted (Henriques, 2014). The participants for the study were selected based on inclusion criteria, and the researcher had no relationship with any of the participants. Henrique (2014) stated that there is a need for recognizing bias, perceptions, or preconceived notions about the problem. Onwuegbuzie & Byers (2014) recommended a solution for the researcher's bias and subjectivity by minimizing or avoiding preconceptions based on experience, knowledge, and beliefs. In summary, the researcher monitored and reduced biases, developed confidence and competence in the research method, collected and analyzed data, presented relevant and trustworthy findings through reflexibility, and gained in-depth knowledge of the subject of the study (Hyett et al., 2014). There were no identified conflicts of interest associated with the research or financial support for this research that could influence the results. The researcher offered no incentive for participation and did not anticipate any conflict of interest or power differentials in fulfilling the role of the researcher.

Methodology

Participants Selection

The participants in the study consisted of 12 Administrators from different Medicare-certified home health agencies in Illinois who are decision-makers within their organizations and have the required experience and expertise that are relevant to the research. Researchers used multiple participants from numerous organizations to conduct a qualitative research study for validity (White & Hind, 2015). A small sample size of study participants facilitated the capture of a thematic experience. The criteria for selecting participants included being an administrator in home health agencies that have been in business for over seven years and have implemented government-mandated requirements for participation in the Medicare program in Illinois.

The sampling method for participants in the study was purposive. Purposive sampling is universally accepted for use in qualitative studies to identify and select individuals or groups with relevant information and experiences that are related to the phenomenon of interest (Palinkas et al., 2015). According to Baur et al. (2015), purposeful sampling is a nonprobability sampling method that is effectively used when there is a need to understand participants' perspectives on a subject matter. Purposeful sampling is preferred in an intentional sampling of participants who have suitable information regarding the research topic (Palinkas et al., 2015). Therefore, participants were selected based on their capacity to provide rich data that is relevant to the topic under investigation. According to Creswell & Plano (2011), the purposive sampling method allows for efficient use of time and resources in data collection and saturation

using knowledgeable and available participants that will voluntarily share relevant experiences articulately and reflectively.

Participants were screened for selection according to the institutional board (IRB) standards, and I alerted the participants of their privacy rights and freedom to participate, including the right to withdraw from participation at will during the research process without fear of retaliation or adverse consequences through the use of informed consent. The selection process commenced with sending out letters of invitation that contained a brief explanation of the purpose of the study and a request for the participants to join the study (Appendix A). The procedure for the identification, contacting, and recruitment of the participants included searching through the Illinois Department of Public Health (IDPH) database for information on the administrators and contacts for licensed home health agencies and the CMS Home Health Compare website for Medicare-certified agencies within Illinois.

Invitation for participation extended to 15 prospective participants to ensure the recruitment of the proposed number of participants. The proposed number of 12 participants responded affirmatively to participate in the study. During the investigation, there was no need for additional participants to reach the point of data saturation. Data saturation occurs when themes become repetitive and do not add any new information that is relevant to the research and has yielded enough information to replicate the study that further coding is no longer needed (Fusch & Ness, 2015). According to Vasileiou, Barnett, Thorpe, & Young (2018), the choice of a small sample size for a purposive sampling approach will provide relevant and adequate information for the topic of the

study. The purpose of qualitative research was not for generalization to a larger population but a deeper understanding of the phenomenon (Ravitch & Carl, 2016).

Furthermore, I believed that increasing the sample size may have resulted in the amplification of the differences in opinions that are not only irrelevant but may compromise the conclusion from the study. Likewise, less sample size may have presented an extrapolation problem for the research (Faber & Fonseca, 2014). Faber & Fonseca recommended the use of a large enough sample size that will facilitate new understanding but small enough to contain an analysis of the study. A significant faction in establishing a solid foundation for data collection is in the use of an effective recruitment strategy. The discussion section of the study included the number of individuals who were approached, declined, enrolled, or excluded, and the reasons for their exclusions from the study (Killawi et al., 2014).

Instrumentation

In qualitative studies, researchers are the primary data collection instruments, and the effectiveness of the tool is based on its credibility with the participants that will provide the necessary information (Yin, 2014). Interviewing was the tool for data collection for understanding the issues and challenges that home health administrators in Illinois face due to changes in government regulations and reimbursement policies. Interviewing is a process of asking questions and obtaining participants' responses and was accomplished in many ways, such as individual, face-to-face interviews, and group interviewing (Trigueros & Sandoval, 2018). As the primary instrument for data collection, I used individual face to face, semi-structured interview methods in collecting

data because of its versatility, flexibility, and applicability to individuals or groups (Kallio, Pietila, Johnson & Kangasniemi, 2016). This method allowed me to explore in depth and to expand on the interviewee's responses in a study (Jong & Jung, 2015). Semi-structured interviews enhanced the researcher's ability to solicit the participants' views and descriptions with the benefit of uncovering issues that may not be anticipated by the researcher. Trigueros & Sandoval posited that the method could reduce the researcher's control over the interview, if not effectively managed.

The semistructured interview consisted of eight open-ended questions that were formulated by the researcher and guided by the identification of themes in a consistent and systematic manner to prompt elaborate responses (McIntosh & Morse, 2015). These questions were applied consistently, using an interview protocol (see Appendix B). The use of a protocol helped the researcher to remain attentive to the participants' answers and to respond with probing follow-up questions for depth as needed. The data collection processes and sources generated large amounts of information for recording by note-taking or audio recording during the interview for verbatim transcription before initiating data analysis (Sutton & Austin, 2015). Lastly, I reviewed the field notes and maintained a journal during the research for referencing and refreshing the collected information.

I used the member checking method to validate participant responses and evaluate the trustworthiness of the results (Birt, Scott, Cavers, Campbell & Walter, 2016). Harvey (2015) believed that member checking is useful in improving the accuracy, credibility, and validity of participants' contributions to qualitative research. The technique was essential in understanding participant responses by presenting an opportunity for

participants to clarify their responses and add more information to confirm the accuracy of the data collected (Harvey, 2015).

Procedures for Recruitment, Participation, and Data Collection

Participants' recruitment strategies included obtaining potential participants' contact information through public records such as the Illinois Department of Public Health database and CMS websites for research statistics and data, formatting, and sending out recruitment letters to the potential participants. The solicitation letter contained information about the study and the researcher's contact information for contact if interested. The letters were delivered via email and face to face verbal invitation to join while giving out the letter of invitation, followed by a phone or email contact without making the potential participants feel pressured to participate (see Appendix C for Participants Follow-up Letter). The participants were directed to review the informed consent form regarding the purpose, intent, and participation in the study before participating in interviews.

Data Collection Technique

The researcher was the primary instrument and was responsible for all data collection, aggregation, analysis, and reporting of the findings (Quinney, Dwyer & Chapman, 2016). Techniques for the data collection included the use of semi-structured interviews, a review of related documents, and a field note to write down discussions. A semi-structured interviewing strategy consisted of the use of open-ended questions that were developed using the vocabulary of a fifth-grade reading level for clarity and ease of comprehension. The interviews were conducted at participants' offices, which promoted

comfort, protected privacy, and facilitated personal contact with each participant (Creswell, 2013). The interview questions were useful in initiating a dialogue with the interviewee about the topic areas that needed to be explored and provided an opportunity for the interviewer to probe into other lines of inquiry that were introduced by the interviewee (Creswell, 2013). The semistructured interviewing format also offered a chance to yield and clarify information that is easy to analyze (Quinney et al., 2016). The semistructured interview strategy included the use of open-ended questions that are designed to explore the participants' experiences and knowledge regarding the effects of the changes in government regulations and reimbursement policies on home health administration in Illinois. Open-ended questions also allowed the participants to share their experiences and perspectives (Quinney et al., 2016; Yin, 2014). Data collection continued until the researcher reached data saturation when the acquired information became adequate to support the study. The duration of each interview was approximately 45 minutes to 1 hour based on the responsiveness of the participants. Most of the interviews were audio-recorded with the consent of the participants with three exceptions. The researcher manually took detailed notes of the conversations, especially of the ones that were not audio recorded during the meeting, to ensure that critical issues that are discussed are not left out of the collection. The records captured the needed information on the characteristics of the participants and their responses to the questions, comments on impressions, behaviors, and non-verbal cues that could not be achieved by the audio recording during the interviews. The note also included circumstances that could influence the participation of the interviewees. The identified circumstances were

considered as part of the research for exciting research results. The audio and written notes were transcribed and saved in the computer after each interview for coding.

The purpose of interviewing was to obtain specific kinds of information in the participants' voices and languages for answering the research question (Jong & Jung, 2015). A last resort for the data collection plan was to mail the interview questions to the participants that are unable to participate in a face to face or telephone interview and follow up with them for responses (see Appendix E). Even though there was no need for the researcher to mail out the interview questions, a self-administered mailed or Internet-based method of data collection is still practical methods of data collection and costs less when compared to other data source methods (Ponto, 2015).

Procedure for Data Collection

I used an interview protocol to maintain consistency in conducting the interviews. I started each interview session with an introduction of myself and the purpose of the meeting. After the introduction, I initiated a social conversation about a common interest, such as places of work and professionalism. I shared experiences to build rapport and trust before immersing in the intense data collection process (Onwuegbuzie & Hwang, 2014). I ensured that the participant was relaxed and comfortable to share information by being conscious of my nonverbal communication, such as smiles, seating position, and eye contact, which could be misinterpreted by the participants (Quinney et al., 2016). At that point, I asked for and obtained the participant's consent to audio-record the conversation before turning on the recording device. I maintained eye-level contact and allowed the participant adequate time to respond to the questions without

interruption. To ensure the accuracy of the participant's response, I occasionally clarified as well as summarized the participant's responses for affirmation. After each interview session, I asked the participant for permission for a follow-up process if necessary. I thanked the participant for the opportunity to share information with me as I conclude the session.

The site selections, times for the interviews, and who to include in the study are relevant aspects and sets the parameters of the proposed research design (Maxwell, 2013). Therefore, the above factors were considered to ensure proper alignment with the research questions for the retrieval of the information needed to answer the question (Creswell 2013; Maxwell, 2013). An effective interviewing technique broadened the depth of the knowledge that was sought after by harnessing the experiences of others to constructively compose the understanding of a phenomenon (Quinney et al., 2016). The locations and times for the interviews were limited to the participant office settings by the participants' choice that provided opportunities for privacy, safety, and interaction within the Chicago metropolitan area. According to Quinney et al., a physical space for interviewing requires attention to details during the data collection planning phase because space can influence understanding, expression, and communication. These authors also believed that a conducive setting for interviews is one that promotes trust, minimizes conflicting pressures, and confusion regarding the purpose of the meeting and preserves the ethical considerations of the study.

The follow-up process during and after this study was a vital component of this research because it increased the overall effectiveness of the researcher's effort and

presented an avenue to thank the participants for their time and contribution (Salkind, 2010). Follow up procedure was relevant in this study for clarification of information and to provide information to the participants if requested (Salkind, 2010). The follow-up methods included phone conversation and were discussed with participants during the initial contact. The follow-up process presented an opportunity to address any questions that the participants had as well as to confirm the responses provided during the interview or to elaborate on relevant data provided to me. This process also served as a strategy to ensure the accuracy and reliability of the data (Torreance, 2012).

Interview Questions

Scheduling of a semi-structured face to face individual interviews to discuss the following open-ended questions and answers depicted the successful recruitment of participants and support data mining.

Question 1: How have the recent changes in government regulations impacted the overall administration of your home health agency over the past 7 to 10 years?

Question 2: How has the restructuring of the Medicare payment system affected the economic aspect of operating your organization?

Question 3: What are the challenging aspects of implementing and sustaining government regulations within your organization?

Question 4: How have these challenges affected your role as the administrator?

Question 5: What strategies have your organization adopted to cope and align its goals with the regulations and policy mandates?

Question 6: What innovations have emerged in your organization as a strategy towards meeting the government-imposed mandates on home health agencies?

Question 7: What strategies have your organization employed to ensure quality and safe care delivery amid dwindling reimbursement?

Question 8: Please provide any comments that you feel are important for keeping home health services as a health care option in the midst of evolving government regulations and policies on home health care.

According to Bengtsson (2016), verbal and non-verbal interaction between a researcher and the participants determines the relevance of the data collected. Therefore, it was essential that the spoken or written questions are formulated appropriately and adapted to the claims of the referenced method to enhance the understanding of the phenomena that is under study.

Relevant points from discussions and information obtained from the interviews were handwritten in a designated field note/journal for recording observations of non-verbal communications such as facial expressions, the tone of voice, and body language during the interviews (Quinney et al., 2016). I also obtained participants' consent to audio-record the discussions on a digital voice tracer device that reduced background noise while capturing the voices, emphasis, tones, timing, and pauses in the recording that may be difficult to write down (Sutton and Austin, 2015). I maintained a journal to

complement audio-taped interviews. Field notes provided vital context to the interpretation of audio-taped data. They served as a reminder for the researcher of unique situations during the interview that facilitated data analysis (Sutton & Austin, 2015). The audio-recording of data collected were transcribed verbatim before initiating data analysis (Bengtsson, 2016). I used the Scribie transcribing services that were available online at https://scribie.com/ for a verbatim transcription of the audio recordings from the interviews. This service was affordable and had a three days turnaround time for completion. The transcribed text was numbered for easy reference and checked for spelling errors, anonymity, and other contextual information that are relevant to the process (Sutton & Auston, 2015).

Data Analysis Plan

The analytical method for this study was a content analysis method because the method focuses on language as a communication tool in deciphering the content or contextual meaning of the text (Hsieh & Shannon, 2005). Some researchers suggested that the objective of the content analysis was to offer the desired knowledge and understanding of the subject under investigation (Bengtsson, 2016). Bengtsson also indicated that a content analysis method is suitable for qualitative researches because of the nature of the methodology, data collection, sampling, and research questions. The goal of data analysis is to reduce the amount of raw data collected by identifying themes and classifying the information in ways that answer the research question. The research question is what issues and challenges home health administrators face due to the changes in government regulation and reimbursement policies on the home health system

in Illinois. Qualitative data analysis is a method of reducing vast data from various sources to come up with impressions that point to the research question. Data analysis takes descriptive information from interview transcripts, documents, blogs, surveys, pictures, videos, etc. Data analysis also involved multiple tasks such as transcribing inputted data, organizing, segmenting, and coding the transcripts of data collected (Bengtsson 2016; Talanquer, 2014). Most of these tasks were completed manually and complemented by the use of a computer-assisted data analysis software as needed. The transcript was analyzed for similarities and differences through a line-by-line approach. Data analysis also included the identification of recurring themes and patterns for coding schemes (Talanquer, 2014).

The process of data analysis for this study started with the gathering of data, sorting or organizing the data into categories, regrouping the data under themes, evaluating the themes, and preparing a report based on the results of the analysis. I manually produced a coding list, which included explanations of the codes and minimized a cognitive change during the process of analysis to enhance reliability. I used codes in identifying the concepts which served as the bases for data sorting and organization into blocks and patterns (Bengtsson, 2016). The use of content analysis made it possible for the researcher to interpret results from data that are presented in words and themes (Bengtsson, 2016). The method was also consistent in approach for the reduction of data, and summarization of findings minimized the risks associated with the data collection, coding, and analysis (Bengtsson, 2016; Sutton & Austin, 2015).

The method and source of the data collection method by a researcher affected the depth of the analysis. For example, the use of the interview method provided the researcher with the opportunity to explore more than the open-ended, written questions could accomplish (Bengtsson, 2016). Data analysis started from gathering data, sorting or organizing the data into categories, regrouping the data under themes, evaluating the themes, transcribing, and preparing a report based on the results of the analysis (Bengtsson, 2016; Sutton & Austin, 2015). The analytic method also included the review and precoding of essential quotes, frequently occurring words that late became useful during the process of actual coding (Saldana, 2016). Precoding the data by circling and highlighting some words manually for familiarization helped identify the preliminary codes (Saldana, 2016). The method also involved a systematic classification process of coding and identifying themes for proper categorization of texts with similar meanings and was useful in reducing and simplifying data (Creswell, 2013; Sutton & Auston, 2015). The data type in the study was peculiar to qualitative case studies and included verbal, written, or electronic form of text data from interviews, questions, books, and other literature (Creswell, 2013). Due to the anticipated large volume of the expected data from various sources, it was necessary and practical to start the process of data analysis upon receipt of the first respondents' notes. The data review occurred many times on the notes and comments related to shared knowledge and emerging connections during the study (Creswell, 2013). The method of transcribing qualitative data was susceptible to inaccuracy and misinterpretation (Rubin & Rubin, 2012). Therefore,

applying the content analysis method in the transcription process was adequate for analyzing the data obtained from different sources (Bengtsson, 2016).

Available advances in technology, such as computer-assisted qualitative data analysis (CAQDAS) packages, made data analysis possible and more straightforward. The CAQDAS also ensured that all the data collected are pertinent and directly connected to resolving identified research questions (Talanquer, 2014). Many available CAQDAS packages are capable of efficiently and systematically facilitate data-related tasks in qualitative research. While ATLAS.ti was a viable option and comparable to NVivo, some researchers believe that the NVivo database is more user friendly due to its resemblance to the word database. It is also a powerful analytic tool that offers more flexibility of use and the ability to import and export multiple data types (Antoniadou, 2017). The NVivo system was rated high for being user-friendly, features and functionality, integration, customer support, training, and implementation (PAT Research, 2018). According to Creswell (2103), NVivo is helpful in managing, analyzing, and shaping qualitative data for ease of use. The software also had a robust auto coding feature, a free 30- day trial period, and a student's package that made it affordable to use and was the choice of computer software for this study (PAT Research, 2018). The task of data analysis ranged from data search, collection, sorting data sources based on characteristics, segmenting, and classifying data according to themes and formulating visual representations of patterns in the collected information (Bengtsson, 2016). Manual coding in this study was supplemented with the use of NVivo software as needed to understand the topic from the participants' viewpoint. Codes were pulled

together to form themes that became headings for the presentation of the findings (Sutton & Auston, 2015).

Issues of Trustworthiness

Trustworthiness is equivalent to the rigor of a study. It is defined as the degree of certainty in data, interpretation, and methods that a researcher established to ensure the quality of a study so that the study will be considered worthwhile by the readers (Connelly, 2016). There are criteria to evaluate the rigor or assess the trustworthiness of qualitative data. The reliability and integrity of a qualitative study are measured by the credibility, dependability, transferability, and conformability of the research processes and presentation of the outcomes (Creswell, 2013). The journey towards trustworthiness in a research inquiry began with ensuring that the research question was formulated well and substantiated. The appropriateness of the methodology for the research question and the sampling method for the study ensured that the right information was obtained, managed, and systematically analyzed (Baxter & Jack, 2008). The overall scrutiny of the phases presented a clear indication of the trustworthiness of the outcome of the audience (Elo et al., 2014).

The goal of giving credibility to a study is to support the argument and convince readers that the study findings are worthwhile. The trustworthiness process for this study started with the research design, as seen in the choice of purposive sampling for selecting interested participants. They have the experience and expertise in managing a Medicare-certified home health agency. The participants were genuinely willing to participate and offered information freely. Another qualitative research approach to ensuring data

credibility was the triangulation of data sources, data types from various perspectives, and data analysis for confirming the result (Bengtsson, 2016; Maxwell, 2013). Therefore, the choice of the setting, sampling, instrumentation, data analysis, and the outcome was strategically made to ensure trustworthiness (Creswell, 2013; Maxwell, 2013).

Credibility

Bengtsson (2016) defined credibility as a process of ensuring that a researcher considers all relevant data during the process by establishing proper data collection, source, and the analysis procedures in the study. Other authors refer to credibility as an internal validity process that is formed by the researcher (Creswell, 2013; Patton, 1999). According to Patton (1999), credibility in a qualitative study depends on the following elements: (a) the rigorous techniques and methods for data collection with consideration to the validity, reliability, and triangulation processes; (b) the credibility of the researcher as the primary instrument and related training, experience, and; (c) the researchers' belief and philosophy. The selected participants for this study, sample size, and the mode of data collection, which included interviewing as an instrument, are necessary to establish credibility (Connelly, 2016). However, the information obtained by using this method was based on the assumption of truthfulness. This assumption could pose a challenge to the validation of the instrument and the outcome. Hence, the researcher engaged the participants and created an atmosphere of trust for building relationships. The relationship was based on honesty and transparency with the participants to enhance their comfortability in sharing detailed information during the sessions (Connelly, 2016;

Shenton, 2004). As much as was possible, interviews were tape-recorded and transcribed verbatim to ensure and preserve the integrity of the data (Sutton & Austin, 2015).

Another strategy to ensure credibility was triangulation (Bengtsson, 2016). Data sources for this study included a combination of multiple data sources from individual interviews with open-ended questions, document review, and government websites, which enhanced the understanding of how changes in government regulations and reimbursement policies affected home health administration in Illinois (Heale & Forbes, 2013). Triangulation provided a solution to the problem, data accuracy, explanations, and saturation that compensated for specific limitations while the researcher exploited the particular benefits of each source. (Morse 2015; Simon, 2011). Also, triangulation expanded the knowledge of the researcher and checks for the consistency of data across different collection methods and data sources. The collection, analysis, and comparison of data, enhanced data quality, and collaboration of the information from various sources and based on the convergence of available information, the confirmation of truth in the findings is possible (Creswell, 2013).

Credibility in a qualitative study was achieved by allowing member checks. Some researchers refer to member checks as "the heart" of credibility (Anney, 2014). According to Anney, researchers are required to involve the participants in the data analysis and interpretation process by sending analyzed and interpreted data to the participants for an opportunity to reject or affirm the interpretation.

Transferability

Transferability refers to generalizability or the external validity and is defined as

the extent to which the outcome of the study can apply to other settings or situations using the same process for extrapolation (Connelly, 2016; Shenton 2004). Achieving transferability was dependent on the researcher's ability to provide precise descriptions of the context, selection, and characteristics of participants for the study. Detailed information on the fieldwork, environment, data interpretation, analysis process, and presentation of the outcome was vital for proper application to other settings or situations (Elo et al., 2014). Also, the use of purposive sampling in the study aligned with the purpose of the research and the research question, which facilitated the researcher's focus on participants that are knowledgeable of the issues under investigation (Anney, 2014).

Dependability

Dependability refers to the stability and consistency of the research findings over time (Anney, 2014). It is also similar to reliability in characteristics and ensures that the researcher is aware of and documents anticipated and emerging changes that can influence the process (Frels and Onwuegbuzie, 2013). Dependability was achieved by ensuring credibility in the methods, keeping a personal journal that is reflective of the study activities, and documenting my progress during the research process (Anney, 2014). The audit trail established the confirmability of the study. Audit trails by an external auditor to confirm the collected data supports the accuracy of the findings as a means of ensuring dependability (Yin, 2014). A thorough audit trail to cross-check the study process: raw data, interview, and observation notes, documents, and records collected from the field, and others were used in confirming the dependability of the study findings (Munn, Porritt, Lockwood, Aromataris & Pearson, (2014). I also implored

other methods such as triangulation and member checking to enhance thoroughness in the study and also presented the participants the opportunity to clarify, review and add to the data for accuracy (Anney, 2014). The process of member checking facilitated the establishment of the trustworthiness of the data collection and interpretation process (Fusch, & Ness, 2015).

Confirmability

The relationship between the research and researcher is paramount to the viability of any study, and the essence of qualitative research puts the researcher in the study as the primary instrument (Ravitch & Carl, 2016). Hence the researcher's positionality, reflexivity, and bias may influence the research process and outcome (Bourke, 2014). I ensured that the findings presented in this study reflected the true experiences and ideas of the participants for confirmability. Admitting my predispositions was vital towards the confirmability of the study. Therefore, my beliefs and underlying reasons for preferring one approach to another when other methods and biases are viable options for the study were added to the report (Yin, 2014). My goal is to recognize any bias, the effects of my beliefs and assumptions on the research, and adequately record the participant's voices and perspectives (Yin, 2014). I narrated a detailed description of the methodological to portray the integrity of research findings in case of any examination.

Ethical Procedures

The proposed study, like others, was subject to specific ethical considerations to ensure that the research process did not physically or psychologically cause any harm or abuse to the participants (Dooly, Moore & Vallejo, 2017). Ethical challenges may occur

at any phase of the research and may include anonymity, confidentiality, informed consent, the researcher's potential impact on the participants (Sanjari et al., 2014). Protecting participants' privacy in a qualitative study where a participant could share personal and organizational information was paramount, especially with the ongoing technological advancement and dependence (Ravitch & Carl, 2016). A potential violation of participants' and corporate privacy was minimized by excluding all identifiers, biographical information, and other personal information from the data collected (Sanjari et al., 2014). To ensure confidentiality and participants' information safety, a researcher may use unique identifiers for each participant (Yin, 2013). Therefore, I assigned an alphanumeric code to each participant containing a letter and the number of their recruitment sequences for de-identification during the data analysis. Participants' data were stored electronically in a passworded system that is accessible to the researcher only. I also maintained a backup flash drive with a password for storing data in case of accidental data loss from the computer while the hard copies were placed in a locked cabinet. Collected data were stored in the form of audio recordings, the hard copy of consent forms that contain participants' identifying information is kept in a secured file cabinet for a minimum of 5 years post-study, after which they will be destroyed. Also, I chose all participants outside the protected class, excluding pregnant women, fetuses, neonates, prisoners, and children (Chwang, 2014). The anticipated risk for participating in this study was not estimated to be higher than regular occurrences in everyday life. I also ensured that the interview questions would not be perceived as offensive or threatening to participants or their employment.

The participants received the explanation and written informed consent form that informed them of their right to withdraw from the study at any time during the process without any consequence. The written form was given to the before enrollment into participation. The voluntary nature of participants' involvement in this study compelled the researcher to inform every participant that they can discontinue their participation in the study without penalty or loss of any applicable benefits. The consent form included an assurance clause that informed all participants of their right to opt-out of the research voluntarily at any time and for any reason during the process (Dooly, Moore, & Vallejo, 2017). I fully inform the participants of the objectives of the study and my obligation towards ensuring confidentiality while ensuring that the data collected are solely used for academic purposes (Issel, 2013; Dooly et al., 2017). The interview protocol and data collection analysis and storage processes were completed per the IRB process to ensure compliance with ethical practices for the protection of participants.

Summary

Chapter 3 included a description of the research design, which comprised of the type of study, sampling, population, data collection methods, and analytical data strategies to understand the subject matter. With the understanding that interviews could be productive as well as time-consuming, careful planning is required to ensure the reliability and validity of the data. Also, the gathering of data from one or more persons required proper training, effective interviewing techniques, adequate preparation, time allocation, and transcription (Quinney et al., 2016).

Chapter 4 included an overview of the study, a description of the data collection process, and a presentation of the findings from strategical data analysis. Also, I summarized the results of the study, the applications to professional practice, and the recommendations, reflections, and conclusions from conducting the study.

Chapter 4: Results

Introduction

The purpose of this qualitative case study was to understand the issues and challenges that home health Administrators in Illinois face amid changes in government regulations and reimbursement on the home health industry. The understanding of the effects of the regulatory and reimbursement changes from the perspectives of the home health administrators have the potential of providing relevant information towards improving compliance, quality of care, and the relationship between lawmakers and home health agency operators. I used a semistructured interview technique to collect data from 12 purposively sampled participants. The participants were identified as administrators from Medicare-certified home health agencies that have decision-making capabilities in the Chicago metropolitan area. Also, I reviewed some literature to answer the research question: what issues and challenges have home health administrators encountered from the changes in government regulation and reimbursement policies on the home health system in Illinois? This chapter includes a description of relevant information obtained during the data collection phase, the setting of the interview sessions, demographics, data collection process, the data analysis process, results associated with the study with evidence of trustworthiness. I concluded the chapter with a summary and transition to Chapter 5.

Demographics

Of the 15 potential participants that I initially contacted, 12 participants agreed to participate in the study. The 12 participants are experienced home health operators with

in-depth information and perspectives on the topic of the study. Seven participants (58.3%) were females, and the remaining five participants (41.7%) were males. All the participants work in home health agencies that have been operational for over seven years in Illinois. Four of the participants have been in their positions as administrators for eight years. Seven participants have been administrators for seven years, and one administrator who was also the owner of the home health agencies has been an administrator for nine years in multiple home health agencies in the Chicago area. The participants were assigned identifier numbers in place of their names to protect their privacies according to the order of recruitment (see Table 1)

Table 1

Study Participants and assigned Identification Codes (N = 12)

Participants' identification code	Gender	Years of experience
HHAM01	Male	7
HHAM02	Male	8
HHAM03	Male	8
HHAF04	Female	9
HHAF05	Female	7
HHAM06	Male	7
HHAF07	Female	8
HHAM08	Male	8
HHAF09	Female	7
HHAF10	Female	7
HHAF11	Female	7
HHAF12	Female	7

Note. HHA – Home Health Administrator M = Male F = Female

Data Collection

Upon the receipt of the Walden University's Institutional Review Board (IRB) approval number for this study -12-12-19-0557009 which expires on December 11th, 2020, I initiated data collection process by sending out an email invitation for participation in the study to 15 identified individuals that fitted the criteria needed for the study. I received positive feedback from 13 participants initially, and one participant withdrew his willingness to participate one week after affirming his interest in the study due to an emergent situation in his workplace. I contacted each participant and scheduled a one- on one, face to face interview at a time and location that is convenient for each participant. All the participants preferred and provided their offices for the interviews to take place.

Securing appointments with the affirmed participants was somewhat challenging due to some participants' and researcher's prior commitments and busy schedules. One on one, face-to-face interviews are efficient in conducting a qualitative study in answering the research question: What issues and challenges have home health administrators encountered from the changes in government regulation and reimbursement policies on the home health system? This technique also facilitated the establishment of rapport with the interviewees and allowed the interviewer to note non-verbal cues as the participants respond to the interview questions (Brinkmann, 2014).

I sent out gentle reminders with possible dates and time frames to schedule interview sessions. Eventually, scheduling all interview dates and times were finalized. I also sent out the research protocol (see Appendix C) and interview questions (see

Appendix E) to the participants for their review and clarifications, as needed, before meeting them for the collection of data. All participants affirmed that they understood the questions and had no need for further clarification before the interviews. Seven out of 12 interviews occurred in the administrators' private office while the remaining five took place in the home health agencies' conference rooms. During the interview session, I ensured uniformity of the process for each by using an interview protocol and a standard format of using the same interview questions for each interview. The eight open-ended interview questions that I used were designed for a 45 to 60 minutes session. All the interview sessions went as planned without interruptions and lasted an average of 45 minutes except for the last interview. The last interview lasted 60 minutes as the participant had so much relevant information to share from a binder that contains notes that the participant put together regarding the agency's process in response to some of the changes in regulations.

All the participants expressed interest in the topic of study and were eager to share their experiences. Nine out of 12 participants gave permission to be audiotaped and transcribed. Data were collected from 12 home health administrators through a face to face and one-on-one interview process. With participants' consent, interviews were recorded in on an android device during the interview in addition to field notes that contained situations and reflections that are vital to the process during the interviewing sessions. The interview process for the three participants that declined to be audio-taped during the process was slightly modified to accommodate the deviation from the planned interview sessions. I gradually paced the interview questions for those that were not

audio-taped to allow extra time for writing down their responses. I also asked the participants to repeat the statements that I could not manually record when stated for accurate documentation. At the end of the interview with each of the three participants, I read back each question and the participants' responses to the participants to verify that I captured everything the participants shared during the interview.

Data collection also included a review of public documents from the CMS and Illinois Department of Public Health (IDPH) websites and related articles. Data obtained from the analysis of documents and websites were also compared with the participants' responses to the interview questions. The data collection process was initiated from the middle of December 2019 to the end of January 2020. I reviewed the recorded interview and manually transcribed and updated the transcripts in Microsoft Word document to ensure the accuracy of the recordings. I forwarded the transcript of each interview to the applicable participant to verify modification as needed and the accuracy of perspectives. The variation identified in the data collection plan was related to the lack of audio-recorded transcripts for three out of the twelve participants in the study. This variation was managed by slightly altering the interview process to accurately reflect the totality of the interview, as described in the previous paragraph.

Data Analysis

A content analysis technique was used to reduce the amount of raw data without losing relevance. I organized and reviewed the raw data gathered from interviewing 12 participants, interview notes, and reviews of articles and input the data into a word document to identify recurring ideas and keywords through a line-by-line approach.

Emerging codes from the analysis were appropriately categorized to correspond to the interview questions and were used as the basis for the data analysis. Manual coding and categorization were supplemented with the use of NVivo 11 software, which is an analytical software that I used to manage and analyze my research data for efficiency and accuracy in the retrieval of the coded data for analysis (Woods, Paulus, Atkins, & Macklin, 2015). The NVivo software has functions that allowed me to create text files for my field notes, interview notes, and transcribed audio-recorded data into notes. The audio-recording of data collected during the interviews was transcribed verbatim through Scribie transcribing services, which are a secured online service that specializes in the verbatim transcription of the audio recordings. The transcribed text was numbered for easy reference, accuracy, anonymity, and other relevant contextual information. The task of data input, coding, and categorization was completed manually. The recording and field notes from the interviews were transcribed and imported into NVIVO 11 for content analysis.

Recurring phrases included changes in health policies and reimbursement, decreased census, delayed payment, elimination of initial payment for home health episode, limited resources, heightened scrutiny, audits, PCR, demand for quality, limited resources, decrease in staff and home visits, EHR, RPM -Telemedicine, patient education, business diversification, increase in staff responsibilities, home health agency closures, prosecution of owners and operators, moratorium, decreased awareness of future planned changes, more hospital-based home health services to increased competition in recruiting patients. These codes were developed to organize and

categorize data for themes. The themes that emerged from the codes are financial hardship, enforcement of regulations, recent innovations, and feeling of uncertainty regarding the future of small home health organizations. All the research data were organized into folders and labeled with the assigned codes to protect participants' identities. These folders were stored in a passworded flash drive known only by the researcher for safety and will be securely kept for at least five years.

Evidence of Trustworthiness

Credibility

Credibility for this study was achieved through rigorous techniques and methods for data collection, triangulation process, and member checking strategy. Some Interviews were manually recorded, while the majority of them were audio-recorded and transcribed verbatim to ensure and preserve the integrity of the data (Sutton & Austin, 2015). This study was conducted using multiple data sources that included face to face individual interviews with open-ended questions, document reviews, and government websites to enhance the comprehension of the phenomenon under study (Heale and Forbes, 2013). For credibility, I combined three data collection methods - interviews, field notes, and document reviews through methodological triangulation. Triangulation provided a solution to the potential problem of data accuracy and saturation while adding to my knowledge of the research through checking data consistency across the different data collection methods and sources. The collection, analysis, and comparison strategies enhanced data quality and collaborated the information from various sources and the confirmation of truth in the findings. Member checking was used

to ensure the accuracy of interview data and added to the credibility of the study by granting the participants the opportunity to review, reject or affirm the interpreted data (Marshall & Rossman, 2016)

Transferability

Transferability in qualitative research refers to the extent to which the study findings can be replicated in other contexts and was achieved by the presentation of a detailed description, including the underlying assumptions that are pertinent to the study (Anney, 2014; Baille, 2015). To achieve transferability, I documented each phase of the study process from participant selection, data collection, interview sessions, environment, data interpretation, and analysis to the presentation of the finding to ensure replicability of the research methodology. The procedures used in my study were presented consistently to enhance comprehension so that the study can be replicated in the future by other researchers

Dependability

Dependability is similar to reliability and depicts the stability of the results for the inquiry over time. Dependability was achieved by ensuring credibility in the methods and proper documentation of the research process and finding (Anney, 2014). Dependability establishes that the research findings are consistent and repeatable, which is the reason for verifying the consistency between the discovery and the raw data that I collected from multiple sources (Fusch, Fusch, & Ness, 2018). I performed an audit trail of the data collection, recording, and analysis strategies. I reviewed my field notes from the interviews and documents from other sources to confirm the dependability of the

study findings. I used triangulation and member checking to ensure rigor in the study and present opportunity for members to review, affirm, and add to their data for accuracy (Fusch et al., 2018). By using member checking, which Anney (2014) referred to as "the heart of credibility," I established the trustworthiness of the data collection and interpretation.

Confirmability

Confirmability ensures that the result of the inquiry can be corroborated by other researchers as authentic, derived from the data and analysis, and devoid of the investigator's bias and imaginations (Anney 2014). I followed the process that I outlined in Chapter 3 to ensure confirmability for this study. In addressing the issue of confirmability, I chose the purposeful selection of the participant. As the primary instrument in the study, I ensured that my reflexivity and bias did not influence the process and the outcome. The findings presented in this study represent the experiences, narratives, words, and perspectives of the participants rather than the thoughts, position, or background of the researcher for confirmability. I provided a detailed description of the methodology for the study to show the integrity of the outcome and audited the process from my notes to facilitate replication opportunities in the future.

Results

Per the outlined methodology in chapter 3, the results presented in this inquiry emerged from the data gathered through interviews, field notes, and document review to understand the issues and challenges that home health Administrators face due to changes in government regulations and reimbursement on home health agencies in Illinois. The

in-depth analysis of the participants' responses to the interview questions resulted in the appropriate categorization of coded data that led to the development of correlated themes. The emerging codes and themes are presented in Table 2, followed by the details of the participants' responses that are arranged in themes.

Table 2

Emerging codes and themes

Interview Questions	Codes	Theme
1,2,3,5	Changes in policy, ACA, cut in reimbursement, decreased census, delayed payment, elimination of initial payment for home health episode, limited resources	Financial hardship
3,4	Heightened scrutiny, audits, PCR, demand for quality, limited resources, lack of provider education	Enforcement of regulations on home health businesses
4,6,7	A decrease in staff and visits, EHR, RPM -Telemedicine, patient education, business diversification, increase in staff responsibilities	Recent strategic innovations
8	Home Health agency closures, prosecution of owners and operators, moratorium, decreased awareness of future planned changes, more hospital-based home health services, and increased competition to get patients	Uncertainty about the future of small home health business

Theme 1: Financial hardship. All the participants expressed how the changes in government policies and reimbursement have affected their fiscal operations, especially

the agencies' finances, which are tied to compliance. Interview questions 1,2,3, and 5 addressed the perception of the participants regarding the recent changes in government regulations and reimbursement policies and how these changes have impacted the finances, compliance, and their roles as leaders. Participants HHAM01 and HHAF04 admitted that their agencies' board members had, at some point, recommended shutting down operations due to lack of adequate funding resulting from decreased and delayed Medicare payments. Participant HHAM01 stated that their organization had to take out loans and a business line of credit to support payroll since the implementation of the pre-claim review process. Participant HHAF10 said, "I had to pick up direct care services, performing home visits to cushion the demand for nursing staff that we could not afford to retain due to lack of funds to pay them." Participant HHAM02 described the constant changes in government regulations and enforcement of policies as "counter-productive to quality and safe service delivery." He further stated that the burden of proof that some of the home health regulations had placed unnecessary regulatory and financial constraints on the business operations. Participant HHAM03 added that "as well-meaning as these changes could be, it puts small businesses at a disadvantage in compliance when compared to the health systems that have dominated the home health service delivery sector. All the participants acknowledged that the aim of healthcare reformation through the policy and regulation changes is on improving the quality and safety of care while reducing costs.

Theme 2: Enforcement of government regulations on home health business.

Interview questions 3 and 4 focused on the challenges of implementing the changes and the strategies that the organizations adopted to achieve and sustain compliance. Participant HHAM06 noted that the condition of participation for Medicare programs is a bulky document that required full awareness and comprehension for adherence and that the government has done a poor job of educating the private sector proprietors on the expectations. He added that a lot of agencies have fallen short of these expectations due to lack of knowledge and that their non-compliance has triggered heightened government oversight and scrutiny on the home health agencies. Participant HHAM08 narrated how they have spent time and resources trying to respond to government audit results on their business for services that were provided 2 to 3 years ago and subsequent request to return the payments that Medicare made for most of the physician-ordered services that were provided to beneficiaries. He also added that the home health agencies and referring physicians need to be educated on the proper process and documentation of the face-to-face encounter requirements for the initial certification of care. Participant HHAF11 stated that her agency's claims were denied in the past due to what Medicare determined was inadequate clinical documentation on the face to face certification by the physician even though the process was followed. Participant HHAM02 stated, "even in the face of increased and improved regulations and audit process, the demand for quality of care will still be jeopardized if we cannot fund it." Participant HHAF07 stated that compliance and education of home health personnel require resources that are being marginalized for

home health services but that the agencies continue to struggle towards compliance because many family and professional livelihood depend on the revenues that the business generates.

Theme 3: Recent strategic innovations. Most of the participants laughed when asked about their agencies' strategies to remain and continue to strive for compliance in the business. Interview questions 4 and 6 addressed the issue of coping mechanisms, and strategic innovations for meeting Medicare imposed mandates on home health providers. Six out of twelve participants shared that in the wake of increased government attention to home health agencies due to the rising cost of care, their agencies had to diversify the services they provide to sustain operations. Participants HHAF04, HHAF05, HHAM06, HHAF09, HHAF10, and HHAF12 stated that their agencies added homemaker services to the home health services they provide for business expansion and financial reasons. Also, Participant HHAF05 indicated that she took on field assignments to augment clinical staffing visits and that her agency staff members have engaged in Medicare webinars and other forms of training regarding the recent changes in regulations and policies. She admitted that the information was helpful but preferred some sort of government notification of businesses on the implementation of the mandates.

Furthermore, all the participants acknowledged the impact of integrating technology, such as electronic health records (EHR) and telehealth in their agencies. According to these participants, health information and evaluation technology have become very instrumental in improving compliance, quality of care, and decreasing service costs despite lack of incentive or reimbursement from the regulators.

Participants HHAM01 and HHAM02 shared that they have been able to successfully reduce the number of face to face clinician visits to the homes of some of their stable patients by telehealth monitoring, thereby saving cost and remaining compliant while providing quality care to the satisfaction of the beneficiary. Participants HHAM03, HHAF1, HHAF07, and HHAM08 narrated the perks of integrating the use of technology in their agencies. These include better scheduling, efficient communication, timely intervention, improved information sharing among providers, cost savings, better documentation, easy access to patient records, protection of patient information, and increase patient satisfaction.

Theme 4: Uncertainty about the future of small home health businesses.

Interview question 8 produced fascinating responses, feelings of fear, and concern for the continued existence of private home health business as a health care option for Medicare recipients. Participant HHAF04 who has over 15 years of experience in home health services and nine years in leadership, stated narrated her experience with the trajectory of the changes in government regulations and reimbursement over the years as a clinician and a leader in the service industry. She said

> Home health services have changed a lot. There was a time during the Clinton era that home health services were reimbursed adequately without much scrutiny or delay in payment, but then, the country's economy was in surplus. There were value and dignity in the services we provided without question, but now, many proprietors entered the market with only one thing in mind – make a profit. They also took advantage of the lack of proper oversight from the government to

> engage in some illegal practices that awoke the giant -Medicare- from slumber to start looking into the actual cost of health care from the home health sector as it rises more than expected. As it is now, many agency operators are in jail, and fear has graced the industry. So, everyone that wants to remain in this business needs to be alert, careful, and honest.

Participant HHAF10 stated that changes in the regulations of the home health industry will continue to occur in response to market and industry activities to maintain the integrity of the program. She said

> I am aware of some agencies that have either been forced out of business through regulations or opted to shut down operations due to a lack of coping strategies. Many years ago, some organizations that have home health license in Illinois could not function due to a ban on Medicare enrollment. Subsequently, they had to shut down after investing money and time to license and operate the agency. I thought the end of privately owned home health businesses is around the corner, and with the advice of the board, we had to venture into other service areas.

Participants HHAF07, HHAM08, HHAF09 eluded to an increased level of competition for patients with other home health operations that are run by hospital health systems that were the primary source of referral for home health services for privately owned small home health organizations. Participant HHAF09 stated that the decline in the patient census in her agency from 115 to 55 patients significantly impacted staff retention and operations. She attributed the dramatic decrease in the agency's patient count to the lack of referrals for services from the local hospitals. The rest of the participants are skeptical

but believe that home health services will remain a viable option of health care for clients in their homes, especially with the increasing number of the aging American population with increased life expectancy and living with acute and chronic conditions. All the participants also agreed that proper oversight is required to keep the honest, hardworking, and compassionate providers in the home health business.

Lastly, the participants expressed their concern over the recent change in payment model from PPS to Patient-Driven Groupings Model (PDGM) with its related requirements. The fear ranged from what the changes will mean to the agency that will be needed to implement the necessary changes without going out of business. However, the participants also suggested that home health agencies need additional support for increased utilization, payment, and meeting the requirements of service delivery reforms.

Summary

In this chapter, I described the study setting, the demographics of the research participants from purposive sampling who possess in-depth knowledge of the home health regulations, and reimbursement policies. The group of participants formed an excellent representation of administrators from Medicare-certified home health organizations across Illinois with the responsibility of overseeing the provision of services efficiently and cost-effectively while complying with Medicare's conditions of participation. There was a consensus agreement among the participants about the financial, compliance, and innovation implications of managing the imposed regulations and funding for home health businesses. Also, there were expressions of skepticism regarding the posterity of the home health services from privately owned small

businesses as the participants foresee an era where large healthcare organizations will monopolize home health care. The administrators advocated for more positive government intervention to support home health agencies in resolving the challenges resulting from the constant changes in government regulations and policies on home health administration.

Chapter 5 will contain an interpretation of the results based on the findings and scope of the study. I will also describe any limitations that I encountered during the study, recommendations for further research based on the limitations and the implication for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative case study was to understand the issues and challenges that home health Administrators in Illinois face amid changes in government regulations and reimbursement on the home health industry. The research question for this study was: What are the issues and challenges that home health administrators encounter from the changes in government regulation and reimbursement policies on the home health system in Illinois? The understanding of the effect of the changes in the Medicare program regulations and reimbursement policies will foster the development of strategies by home health agencies towards compliance and sustenance while delivering the demanded quality services to Medicare beneficiaries. I explored the perceptions of the home health agencies administrators regarding the effects of the implementation of the changes in home health regulations and reimbursement policies over the past seven years.

I used a semi-structured interview data collection technique, which included the use of eight open-ended questions to answer the research question. The interview process involved 12 home health administrators from Medicare-certified home health agencies in the Chicago metropolitan area that has been in business for seven or more years. I addressed the research question of what issues and challenges that home health administrators encounter from the changes in government regulation and reimbursement policies on the home health system. To ensure credibility and understand the findings, I

collected data for the study from multiple sources such as interviews, documents, and government website reviews. According to Depoy & Gitlin (2015), triangulation from various perspectives can yield a comprehensive understanding of an issue through multiple viewpoints. The institutional theory was the theoretical foundation for this study, which posited that organizations function within a social network and display different firm behaviors in response to environmental pressures that could influence the leaders and organization's behavior towards conformity to rules. This theory suggests that organizations survive by gaining legitimacy through acceptance and compliance with mandates from external mandates. Based on the Institutional theory foundation, the review and analysis of data revealed internal changes within the organizations in response to external regulations of the home health business. The themes that emerged from the grouping of similar responses included: (a) financial hardship, (b) enforcement of regulations on home health businesses, (c) recent strategic innovations, (d) uncertainty about the future of small home health business. These findings support suggestions from previous studies that there are effects of government regulations and reimbursement policies on home health service provision that could be deemed constraining as well as innovative (Kruse et al., 2014; Landers et al., 2016).

Interpretation of the Findings

The findings from the study conformed with the current literature. They supported the results by previous researchers on the effect of the changes in government regulation of home health care and the impact of the reimbursement policies on the operation of the home health care businesses. This section contains the alignment of the

findings with the theoretical framework, interpretation of the themes that emerged from data analysis, and how they affect the perceptions of the home health administrators on understanding the effect of the changes in government regulations and reimbursement policies.

Alignment of Findings to the Theoretical Framework

The data collected in this study were interpreted through the lens of the Institutional theoretical framework for clarity in explaining the findings and answering the research question. The assumption from this theory that organizations' conformity to federal and state requirements shapes and influences organizational and leadership behavior to remain viable within a social network was substantiated throughout the findings (Vadeboncoeur & Jennifer, 2018). Many home health businesses were forced out of business since the implementation of changes in the Medicare payment system. The remaining home health businesses had to device coping strategies toward survival. These deviations, which included alterations in personnel duties, operating on loans, reduction in the number of staff and visits, embracing telehealth, etc., were influenced by external factors from the implementations of regulations on the home health business. These coping mechanisms and strategies that were applied by the participants to keep the home health business operations depicted deviations from their typical modus operandi. These changes in organizational and leadership behavior were imperative for business viability, conformity, and compliance with federal regulations and Medicare policies.

Financial Hardship

Financing the home health business operations and managing the challenges resulting from the implementation of the Medicare Prospective Payment System (PPS) resonated among the participants as they narrated their experiences on working within the wavering payment structure. Their experiences were linked to federal government cut in Medicare reimbursement for home health care services in 2015 and the cascading reduction of another $25 billion from the home health care system up till 2019, through a rebasing process (Forum on Aging, Disability, and Independence; Board on Health Sciences Policy; Division on Behavioral and Social Sciences and Education; Institute of Medicine; National Research Council. The Future of Home Health Care: Workshop Summary, 2015).

The changes in the payment structures included the rebasing implementation over four years thereby, decreasing home health visits by clinicians and access to care for some patients. Reduction in the Medicare payment also restricted the providers' leverage in profit that could boost service infrastructure and respond effectively to the changing regulatory environment. The expressed frustration over these changes by the participants also supported Landers et al., 2016 conclusion that the introduction of a multiple-level classification scheme in determining payment for home health services placed financial and regulatory constraints on the service providers.

The implementation of the PPS was in response to rising healthcare costs and incidents of abuse and fraud in the Medicare system (Suresh et al., 2014). Consequently, there arose a possibility that some home health agencies could not cope with the financial

implications of compliance to keep the businesses running; therefore, they had to liquidate or shut down operations. The participants shared that many home health businesses sought out other means of access to finances, such as business lines credit to augment Medicare payments to meet their financial obligations. Unfortunately, the ACA eliminated the traditional mechanisms by law for redress from government regulatory excesses by denying health care providers access to judicial review to resolve differences. However, the CMS has shown its willingness to resolve matters with providers productively and efficiently. Also, linking home health service payment to providers' performance that are rated by a third party produces results that may not be justified by the reimbursement rate for home health services. However, there is a shared belief among the participants, in line with some research conclusion, that regulations, despite the related outcomes, are designed to ensure patient safety and access to affordable healthcare, provider accountability, assuring access to quality, and a transformation of the health care system (Wanamaker and Bean, 2013).

Enforcement of Regulations on Home Health Businesses

The initial intention of the Congress was to administer the Medicare program as a federal benefit that is paid retrospectively for medical services provided to the beneficiaries. However, the escalating cost of healthcare has transformed the program from a distributor of benefit to the regulator and enforcer of administrative rules on health care providers, including a restructuring of payments (Kinney, 2015). The Medicare program is guided by multiple, complex legislative and interpretative rules, policies, and computer programs that produced many decisions regarding the administration of the

Medicare program (Kinney, 2015). The participants embraced the need for the regulation of the Medicare program, which provides coverage to millions of beneficiaries in the United States. Hence the vigorous civil and criminal enforcement to reduce fraud and abuse of the program through regulations that will weed out potential and actual violators that are giving business owners and operators bad reputations.

According to Beales et al., (2017), the primary objective of regulation was not to undermine but to enhance societal well-being that is predicated upon a cost- analysis. Despite the limitations of some regulations, regulators must ensure that the rules provide social benefits that are greater than their social costs. In line with this assertion, the participants believed that poor regulatory compliance is prevalent in the home health industry. They shared that the government had not exerted much effort to understand the underlying reasons for noncompliance; instead, the regulatory bodies continue to escalate and intensify the implementation of regulation to the existing and new policies. Home health provider education on evolving rules could allow the administrators to harness the knowledge that ignorance might have created. The participants cited conformation to healthcare cybersecurity standards as one of the challenging processes to implement, monitor, and sustain since the introduction of telehealth for home health service delivery and the mandated EHR on home health organizations. They suggested that some type of financial or educational government incentives could be useful for ensuring that sensitive data and patients' information are protected from loss, theft, or unauthorized access or modification (Mohammed, 2017). While the efficiency of technology in the home health setting may be applaudable, it predisposes the organization to cyberattacks. While it is

not the intention of the home health agency operators to be non-compliant, there are budgetary, technological, and human resources constraints that rendered the small privately-owned Medicare-certified organization to remain non-compliant. The home health administrators deal with these factors that are rooted in the regulatory changes on the day to day operations of their businesses.

Judging from the participants' responses to the interview questions on the regulations of home health services, it was evident that the participants understand the complexity of the regulations and the resulting tension in trying to comply with the standards while responding to the actual situations surrounding the service administration. The participants expressed that the financial challenges that their agencies encounter was as a result of a high level of scrutiny and auditing on home health agencies. This expression aligned with the assertion made by Belinger (2016) that over-regulation of home health businesses by Medicare can result in situations that leave the organizations underfunded and understaffed leading to noncompliance. Given the challenges that the enforcement of various health care policies by Medicare through their contractors, the participants expressed some lessons learned in the process of resolution. These processes included the implementation of policies and procedures to ensure that various aspects of the demands of the program are met promptly. Also, the organizations are documenting and organizing required processes to facilitate seamless review when necessary.

Recent Strategic Innovations

In addition to the increased scrutiny and the escalating nature of government regulatory roles in the home health business, the industry is evolving with much focus on innovation, quality, and strategies that are changing the fabric of home health operations. These evolutions are met with strategic plans from the home health business to become and remain in compliance with mandated changes in regulations. The participants shared numerous strategies and related disruption that they encountered in response to the changes in Medicare policies. For example, the administrators shared some level of confusion in the flow of operation related to human, technological, and other external factors in the process of adopting the use of EHR in their practices as part of the Medicare mandate. The mandated use of EHR was to ensure information sharing and care coordination (Kruse et al., 2014). However, overcoming the disruptions through training and technical support that will support the innovation, was beneficial to the organizations for efficiency in processes. The electronic mode of information management was also extended to accommodate other business development within the organizations and to meet the need for scheduling, billing, and personnel and information management internally.

The participants also added that since patients seem to be discharged home sooner than expected when compared to the past years, the home health agencies have incorporated a wide range of monitoring and wearable technologies that have the potential for facilitating independence for home health care recipients. In support of the assertions of Husebo & Storm (2014), three of the participants spoke extensively on

emerging technologies. These include devices such as personal emergency response systems that are worn by patients to detect falls and affordable traditional telehealth devices that allow clinicians to capture information such as a person's blood pressure or weight more efficiently. Home Health agencies will need to consider the effects of the use of these seemingly efficient devices on the business operation such as the possible reduction in the number of home health visit, the acceptability of the mechanisms by the patients, the sustainability, affordability of the devices in the organization and their affordability (Forum on Aging, Disability, and Independence; Board on Health Sciences Policy; Division on Behavioral and Social Sciences and Education; Institute of Medicine; National Research Council, 2015). According to these authors, home health care technologies are meant to improve and sustain the health of the care recipients, allow the recipients to live at home longer while reducing the cost and rate of rehospitalization.

Uncertainty About The Future of Small Home Health Business

The perceptions and concerns of the participants about the future of small home health businesses in service delivery appear to be slightly different when compared to some current literature. According to Scales (2019), approximately 15 million Americans who live in their homes experience some level of physical or cognitive deficiencies and chronic health issues. As this population increases in the number and live longer, home health services will remain an option for health care delivery.
The growing concern of escalating Medicare health care spending, the era of inadequate supervision of the Medicare program, and the management of funding create some level of skepticism for a flourishing future for the home health businesses. Home health

agencies are expected to conform to the changes in the industry to be able to meet the health care needs of the increasing aging population (Landers et al., 2016). Howbeit, I agree with Wade et al. (2016) that home health services will survive the financial and regulatory hard times advocated for the government to incentivize home health businesses by reducing some regulatory constraints ss evidenced by the changes that have occurred in the Covid19 pandemic government responses.

On the other hand, the threat of competition for home health services from larger hospital systems is real. According to a report from the Kulik (2020) from the Braff Group (2020), a merger and acquisition advisory firm that specializes in home health and hospice, there is a growing trend in the acquisition of home health agencies and joint venture by more substantial health care groups. While other private equity investors have invested in home health sectors to take advantage of the market of the aging population, and the trend continues to rise across the nation.

Secondly, the participants' concern for the future of the home health business is related to the latest Medicare- implementation of the patient-driven groupings model (PDGM) on January 1, 2020, making it the most significant change to home health reimbursement since the initiation of the PPS in 2011. Payment under the PDGM is determined by the needs and the clinical characteristics of the patient, like the timing of the episode, referral source, diagnosis, comorbidities, and functional impairment level instead of the number of visits made by the home health clinicians (CMS, 2019). It is unsure how the new payment structure will affect the home health business operations.

Still, organizations will undoubtedly be required to review patient care protocols to ensure that alignment between treatment and payment.

Limitations of the Study

An authentic presentation of the perception and response of home health administrators to the changing regulatory environment in Illinois was dependent on engagements with the identified participants and a review of the body of literature on the research topic. Limitations of the study included the timing of the completion of the study. The study was conducted when the home health industry was on the verge of experiencing yet another implementation of one of the most significant payment structures – PDGM. The imminent implementation of the change and the participants' lack of adequate information on the PDGM process, compliance, and possible effect on their practice may have influenced the participants' perceptions during the study. Secondly, a sample size of 12 participants from a purposeful sampling from the Chicagoland area may not be an accurate representation of all the agencies in Illinois. Even though data saturation was achieved with the number of participants, generalizing the outcome of the study on a broad spectrum may be far-reaching. However, the result of the study can illuminate the understanding of home health care administrators and operators who have experienced some form of challenges related to the recurrent changes in home health regulations.

Recommendations

The outcome of the study highlighted some areas that I will recommend for further studies. The findings from this study are based on the perceptions of administrators from small Medicare-certified home health agencies in Illinois regarding the effect of the changing regulatory and reimbursement environment of the industry. The uniformity in the responses of the participants, which are also supported by recent literature, raised the need to explore the same concept with participants from larger organizations to determine the peculiarity of the effects of the changes in government regulations on home health business administration. Therefore, further research may extrapolate the universality of the impact of government actions on the home health industry. Furthermore, data from the study shows that there was an increase in mergers and acquisition of home health industry as a survival strategy and opportunities to harness the advantage of the market due to the rise in the number of the populations that qualify for home health services.

Even though the state governments adopt the healthcare regulations from Medicare, the CMS serves the Medicare and Medicaid population. This study focused on the management of the Medicare aspect of the healthcare policies and excluded the state-run Medicaid programs and related rules. A study that will explore the Medicaid program in Illinois could add to the knowledge of the effects of the changes in government regulations and reimbursements on the state level. Also, future studies could be expanded to the other states to see how Medicare regulations and policies have

affected home health administration and how the administrators have responded to the changing regulatory environment when compared to other states in the same region.

Also, Researchers can investigate the same phenomenon on the perceptions of home health administrators about changes in government regulations and reimbursement policies on home health business administration in other States. Conducting similar research in different States could generate results that could lead to the generalization of findings and also allow for comparison between the results of this study and the replication to determine if there are geographical differences.

The emergence of a significant payment structural change – the PDGM- in the home health industry during the study left the participants rather skeptic of how the change will affect the financial viability and legitimacy of small home health agencies through compliance. I will recommend further studies that will explore the effect of PDGM on home health business finances after about a year from the date of implementation.

It will also be interesting to study the impact of home health services on the COVID19 response plan to determine its usefulness to the American public especially during a health crisis or pandemic

Implications

Implications for Social Change

The goal of this study is to understand the effect of the changes in government regulation and reimbursement policies on home health business in Illinois from the perception of administrators. The data from this study can be used to influence social

change by prompting amendments of existing policies or the origination of new regulations that could minimize the administrative barriers in home health regulations. Furthermore, home health administrators might use findings from this case study to identify and implement compliance and management strategies that are essential for the efficient administration of their businesses. For example, more home health agency leaders may be prompted to increase the use of telemedicine that can enable the voice and video interactions in their service delivery model to monitor and communicate clinical information and health-related data from the patients' homes (Radhakrishnan, Xie, Berkley, & Kim, 2016).

The home health service integration into the management of recent public health emergencies, including the Ebola virus disease outbreak in West Africa (2014–2015) and the current Coronavirus outbreak from China to a global pandemic, have demonstrated the importance of implementing emergency planning and response in the community. Practical and coordinated contributions from home health care providers with state and local health departments, in addition to federal agency initiatives, could be achieved with data from this study (Hinton et al., 2015). Highlighting the recent government actions in mitigating the effect of Corona disease outbreak within the communities suggested that the government can be persuaded to bypass or eliminate some red tapes that may obstruct access to home health care for the vulnerable population. The recent easing of government actions to support home health services for home-quarantined, vulnerable people, and activities are positive responses to the challenges in home health service delivery.

Also, the pressing demand for home health care services from an increasingly elderly and vulnerable population who have preferences are met by embracing the use of technological advances to facilitates the rendering of complex care at home (Suk, Hyun, Storfjell, & Kim, 2013). Most older adults desire to live out their lives in dignity amid chronic medical, functional, and psychological disabilities make home health services imperative. Hence, the need to maintain and fund the Medicare program as a viable option of health care, especially for individuals that are homebound. Meeting this need warranted an intentional oversight of the program to ensure access to quality care, agency compliance and accountability, and cost-effectiveness of services that are provided to the beneficiaries. On the other hand, the challenges associated with the government regulations for the common good of the society, as experienced by the home healthcare providers, cannot go unnoticed.

While the government cannot lose sight of the increasing healthcare cost, emerging innovations, accountability, and non-compliance in the home health industry, it is vital to also hear from the home health business operators. An understanding of the experiences of the home health administration under the Medicare rules and guidelines will result in positive collaboration towards achieving mutual health care. These goals include improving access to safe, quality, affordable health care services that are rendered by bona fide, sustained, and certified home health agencies. The responsive strategies by home health administrators to government rules and policies, such as innovative technology, have reduced the barriers to health services that are caused by distance, lack of reliable transportation, and available providers, especially in medically underserved

areas. Therefore, incentives to implement and sustain these innovations should be part of government considerations in regulating the home health industry to ensure a healthy older population.

Finally, the study provides indications to the government regarding the conceptualization of the potential value of home health care through the eyes of the operators. By so doing, the worsening of some of the financial pressures from controlling factors could be eased to give home health business operators more leeway to increase the extent to which they can provide the essential service of improving the health of the community.

Implication for Practice

This study has a clear implication for practice, as summarized in this paragraph. Government regulations and Medicare policies are necessary by law to protect the integrity of the Medicare program and the viability of the home health business. As changes occur in regulations, home health administrators are expected to adapt by developing and implementing managerial and adaptive strategies to resolve the resulting challenges (Hill et al., 2015) correspondently. The findings of this study support the feedbacks from healthcare providers that serve Medicare beneficiaries to CMS and President Trump's charge to government agencies to relieve financial and regulatory burdens by removing unnecessary excessively burdensome requirements for home health agencies (CMS, 2018). Policymakers focus should be on reducing the amount of time and resources that home health administrators spend in compliance activities for mandated regulations that cannot be directly linked to improved access, quality of care,

or cost-efficiency. According to CMS (2018), interviews with diverse healthcare groups, stakeholders, and facilities yielded 3,040 mentions of regulatory and financial burden, and the government is slowly addressing the burden topics that were raised. The response to the current viral outbreak of COVID19 shows that the reaction to the concerns of service providers can be expedited without jeopardizing patient care by choosing patients over paperwork and protocols.

Finally, relaxing some of the obsolete and redundant Medicare rules by the government that constraints ease of administration by home health business as revealed by the findings of this study could save the Medicare Program a projected amount of $5.2 billion and a reduction of 53 million work hours by the year 2021 (CMS 2018). The findings from this study indicated that administrators struggle to formulate and implement initiatives for successful business operations due to increased regulations surrounding the home healthcare agencies. Employing strategic adaptation approaches to fewer and more efficient regulatory mandates gives the home health businesses a competitive advantage and long-term profit margin that will enhance their viability (Kash, Spaulding, Johnson, & Gamm, 2014). The findings from the study may assist policymakers in hastening the lifting of unnecessary regulations and ease related burden on home health service providers.

Theoretical and Methodological Implications

In chapter 1 of this study, I discussed the gap in the literature and knowledge regarding the lack of full comprehension of the impact of the implementation of constant changes in government regulations and funding policies on the administration of home

health businesses (Polsky, David, Yang, Kinosian, & Werner, 2013). The participants believed that some of the changes in regulations and payment structure constitute obstacles to the effective administration of home health business towards meeting the goal of providing cost-effective, safe, and quality care to patients at home. Removing or mitigating the effect of these obstacles will involve understanding the problem from the perception of those that deal with these challenges in their roles in home health organizations, especially in regions that have experienced more regulations than others such as Illinois.

The consensus views across the participants concerning these effects depicted their need to be heard, support for operations by easing some regulations, and the fear of the unknown regarding the continuity of small privately-owned home health services. These findings are relevant for the application of the Institutional theory in this study because the core of the framework is that organizational change is driven more by external factors rather than its functional considerations (Henrich & Argote, 2015). The institutional theory views the viability and legitimacy of an organization as the organization's ability to conform to external factors, in this case, the federal and state requirements, which dictate and influence its leadership behavior (Vadeboncoeur & Jennifer, 2018). This perception can be abated by increasing the policymakers' awareness of the impact of their policies that could result in amendments for improved home health care and management. The significance of this empirical literature reflected on how the regulatory environment for home health business influenced productivity, growth, employment, access to finance, and other economic outcomes. The findings also

supported the notion that burdensome and increased regulatory environment counteract business operations and performance as well as providing strategies for cost-effective and efficient service delivery while remaining compliant with the regulations. The theoretical implication of this study is that these findings might prompt lawmakers to hasten the recommended changes in lifting unnecessary regulations that are cumbersome on small home health businesses.

The methodological decision for this study was based on the nature of the study. The methodology outlined how the research was undertaken and the methods used in attaining the objectives. The methods described the modes of data collection, analysis, and incorporated the researcher's aim and the contributions of the research participants in answering the research question. Understanding the applied methods could be used in the replication of the study with consideration to the limitations to prevent overgeneralization of findings to a large group.

The application of qualitative study design was useful in exploring and narrating the perception of the participants regarding the changes in the home health business regulatory environment. The use of individual interviews presented a platform for close researcher-participant engagement, better understanding, and comparison of shared information with existing literature on the topic. Effective investigation and knowledge of the impact of changing regulations, narrating the process, and interpreting the findings in this study could provide support to help the home health businesses deal with the changing regulatory environment. The acknowledgment of the perceptions and expectations of the participants as representative of a large body substantiated the need

for regulatory support through policy change. This method of investigation yielded knowledge that can be valuable for home health administration and policymakers to become more responsive to home health business operators' needs. The methodology provides the pathway for future researchers in exploring similar topics in other dimensions and locations.

Conclusion

The initial purpose of the home health care program is to ease the transition of patients from acute care facilities to home to reduce cost lower hospital costs, length of stay, and rate of readmission. Given the drastic impact of the recent Covid19 pandemic and the associated inevitable economic crisis, delivering quality health care with limited resources will become even more challenging. Through the lens of institutional theory, I explored the pressures experienced by home health administrator from the government mandate to sustain community health, improve quality, reduce health care spending, and remain compliant with Medicare rules and policies. These challenges were dependent upon the demands from external institutions, which required leadership competence to responds to the pressures to retain their benefits. This study provided a better comprehension of the nature of the present and emerging challenges related to the regulation of the home health business. In coping with these challenges, the participants' contributions highlighted effective strategies that could be implemented towards active management and resolutions.

While the data emanating from this study is essential to inform, they may not be adequate to conclude that the resultant effect will be the enactment of new health policies

since policies represent a combination of competing common good, restraints, and possible solutions. This study was concluded with a thorough explanation of the perceptions of home health administrators regarding the challenges of the changing regulatory and reimbursement environment on home health businesses. The research is especially timely amid the COVID-19 pandemic that prompted the need to reduce the rate of the outbreak by calling for self-quarantine of infected and potentially infected individuals who can still receive care via telehealth in their homes. The elimination of undue administrative and regulatory burdens such as the support for telemedicine and proposed financial aid to small businesses like the home health agencies have proven to be doable in enhancing healthcare financing and delivery without jeopardizing the administration of health agencies. As necessary as regulations might be in the healthcare industry, policies will not be able to measure or substitute the commitment of home health service providers to ensure that the rights and well-being of the recipients of their services are preserved. The relevance of the contributions from this study can be associated with the modification or easing present regulations and the implementation of future government regulations on home health businesses.

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Appendix A: Invitation Letter to Participate in Research and Consent Form

Dear Administrator,

You are invited to take part in a research study about the issues and challenges that home health administrators face amid changes in Medicare regulations and reimbursement policies in Illinois. The researcher is inviting home administrators of Medicare-certified home health agencies in Illinois that have been in operation for the past seven years. I found your contact information online, and as an administrator in the home health industry, I believe that you have had the first-hand experience in dealing with the issues and challenges that home health Administrators face due to changes in government regulations and reimbursement.

This form is part of a process called "informed consent" that enhances the understanding of this study before deciding whether to take part.
This study is being conducted by a researcher named Sally Nwafor who is a doctoral student or at Walden University

Background Information:
The rationale for Home health services is to provide intermittent skilled services, home health aide services, medical social services, and durable medical equipment to the homebound elderly population with multiple acute and chronic conditions, impairments, and disabilities at home. The federal and state government regulates Home Health care through Medicare/Medicaid policies, occupational licensing, state insurance regulation, and the Affordable Care Act. The recent changes to government regulations, Medicare payment, and reimbursement structure have drastically reduced the advance payment to home health agencies, made reimbursement more difficult, caused a reduction in the use of home health services, and forced some agencies to exit the program. While some studies provided a global perspective of how these government regulations have affected home health services, this study will focus on the challenges of the administration of home health agencies in Illinois. Therefore, the purpose of this study is to examine the issues and challenges that are linked to government regulations and reimbursement policies on the administration of home health agencies in Illinois.

Procedures:

1. If you agree to be in this study, the researcher will contact you to set up a convenient time and venue to meet with you.
2. The purpose of the meeting will be for you to participate in a one-on-one interview/discussion session with the researcher.
3. You will have an opportunity before the interview to ask any questions related to your participation in the study
4. The interview questions will be related to the topic of the study, as described above.

5. The interview session will last about 45-60 minutes long.
6. The interview will not involve questions about personal, financial, or confidential information about you or your business.
7. The conversation will be manually, and with your consent, will also be audio recorded.
8. At the end of the interview, the researcher will read a summary of the information that was manually recorded to ensure accuracy.
9. As a follow-up process to the interview, I will share a summary of the meeting with the participants through emails. The summary will be approximately 1-2 pages long and typed in double line space. I anticipate that the review may take about 10 minutes to read.

Here are some sample questions:

Question 1: How have the recent changes in government regulations impacted the overall administration of your home health agency over the past 7 to 10 years?

Question 2: How has the restructuring of the Medicare payment system affected the economic aspect of operating your organization?

Question 3: What are the challenging aspects of implementing and sustaining government regulations within your organization?

Voluntary Nature of the Study:
Your participation in this study is voluntary. You can withdraw from participation in the interview for any reason. There is no consequence for choosing to be exempted from the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time. The researcher will reach out to let you know whether you have been selected for the study. You will be asked to share with the researcher how you would like me to handle the information that I have collected up to that point. You will have the option of requesting the information that you shared with me to be destroyed or returned to you. You can choose to remain in the study and not share any information or answer some of the interview questions.

Risks and Benefits of Being in the Study:
The risk that is associated with your participation in this study is considered minimal. This means that the probability of harm or discomfort anticipated in this study is not greater than the risks people ordinarily encounter in their everyday life. Your participation is beneficial and would add to the current literature and knowledge about government regulations on home health agencies, which may be instrumental in positive policy changes.

Payment:
Gratitude for your time, participation, and contribution will be much appreciated as no monetary or material compensation will be offered for your participation.

Privacy:
The discussion will be manually recorded to capture the researcher's observations of non-verbal communications such as facial expressions, tone of voice, and body language during the interviews. The use of an audio-recording device will be used to capture your contribution as stated to prevent misconstruing what is shared.
The report of the findings from this study will not include the identities of individual participants and details that might identify participants, such as the agency name and location of the study, also will not be shared.

The information that is obtained from you during the interview will be kept confidential, and any specific information that could be used to identify you will not be shared without your express permission. Shared data will represent the combined data of all the participants. The researcher will not use your personal information for any purpose outside of this research project. Collected data will be kept secured by the researcher, manually in a locked cabinet in the researcher's preferred location. Electronic data will be secured by applying password requirements for accessing the stored information. I will also use codes in place of names, and collected data will be stored in a separate area from participants' identifiers. Data will be retained for at least five years, as required by the university. Declining your participation in this study based on your knowledge of the researcher will not negatively impact your relationship with the researcher.

Confidentiality represents a core principle and forms a standard practice in this study. However, I am obligated by law to divulge any knowledge of illegal activities or harm that may be uncovered during the research process. Therefore, I will work within the confines of the laws of the state of Illinois in handling situations that reveal criminal activities during my research process.

Contacts and Questions:
You may ask any questions you have now. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 1-800-925-3368 ext. 312-1210 from within the USA, 001-612-312-1210 from outside the USA, or email address irb@mail.waldenu.edu). Walden University's approval number for this study is 12-12-19-0557009, and it expires on December 11th, 2020. Please print and keep a copy of this form for your record.

Obtaining Your Consent
Please review all the information contained in this form, and if you feel that you understand the study well enough to decide, please indicate by responding affirmatively to my email within seven days of receipt. I have enclosed the complete interview questions for your review.

Sincerely

Appendix B: Interview Protocol Form

Interview Title: Understanding the issues and challenges of government regulations and reimbursement policies on the administration of home health agencies in Illinois.

I will ensure that the consent forms have been signed by all participants before the interview and copies of the signed form will be distributed to the participants

1. The discussion will start with an introduction and greeting.
2. I will thank and appreciate the participants for their time and participation in this study.
3. Inform all participants that the interview will be recorded during the interview session.
4. I will turn on the recording device after determining the readiness of the participants.
5. The interview session will start with question one and progress to the last question.
6. Participants will be encouraged to speak freely and offer any pertinent additional information for clarity and comprehension.
7. I will provide the participant with feedback for validation to improve the accuracy, credibility, validity, and transferability of the study.
8. Participants will be contacted after data interpretation and scheduled for member checking sessions to ensure the reliability and validity of the information that was shared during the interviews.
9. I will ensure that all participants have my contact information in case they need to reach me for questions.
10. To end the interview, I will thank the participants for participating in the study.

Appendix C: Participants Follow-up Letter Template

Date: _____

Participant's Name: _____

Address: _____

_____

Dear _____,

This letter is being sent to you as a participant in the study on Understanding the issues and challenges of government regulations and reimbursement policies on the administration of home health agencies in Illinois.

According to our records, you were scheduled to participate in a face to face interview with the researcher on _____.

I will appreciate your participation as I believe that your input will yield beneficial information into the subject matter of the study.

If you have decided not to participate in this study, please notify us of your decision so that we can update our records. Your prompt attention is appreciated.

Sincerely

Appendix D: Interview questions

These questions are designed to elicit an in-depth response on the issues and challenges that administrators face from the recent changes in government regulations and reimbursement policies on home health administration

Question 1: How have the recent changes in government regulations impacted the overall administration of your home health agency over the past 7 to 10 years?

Question 2: How has the restructuring of the Medicare payment system affected the economic aspect of operating your organization?

Question 3: What are the challenging aspects of implementing and sustaining government regulations within your organization?

Question 4: How have these challenges affected your role as the administrator?

Question 5: What strategies have your organization adopted to cope and align its goals with the regulations and policy mandates?

Question 6: What innovations have emerged in your organization as a strategy towards meeting the government-imposed mandates on home health agencies?

Question 7: What strategies have your organization employed to ensure quality and safe care delivery amid dwindling reimbursement?

Question 8: Please provide any comments that you feel are important for keeping home health services as a health care option in the midst of evolving government regulations and policies on home health care.